DEPARTMENT OF MEDICINE AND SURGERY CONSTRUCTION, MEDIPP STATUS AND RESOURCE ALLOCATION PLANNING; AND PUERTO RICO AND VIRGIN ISLANDS HEALTH CARE PLANS

HEARING

BEFORE THE

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

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DEPARTMENT OF MEDICINE AND SURGERY CONSTRUCTION, MEDIPP STATUS AND RESOURCE ALLOCATION PLANNING; AND PUERTO RICO AND VIRGIN ISLANDS HEALTH CARE PLANS

THURSDAY, FEBRUARY 23, 1984

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9 a.m., in room 334, Cannon House Office Building, Hon. Bob Edgar (chairman of the subcommittee) presiding.

Present: Representatives Edgar, Evans, Mollohan, Penny, Staggers, Rowland, Richardson, Hammerschmidt, Hillis, Bilirakis, and Johnson.

Also present: Hon. G. V. (Sonny) Montgomery, chairman, full Committee on Veterans' Affairs.

OPENING STATEMENT OF CHAIRMAN EDGAR

Mr. EDGAR. The Subcommittee on Hospitals and Health Care will come to order. We are meeting today to receive testimony concerning the Department of Medicine and Surgery's construction program request, as required by section 5004 and section 5007 of title 38, United States Code. Additionally, we wish to learn of the impact of the medical district initiated planning program [MEDIPP], upon this year's construction request. We are also interested in learning of the Veterans' Administration's plans for meeting the health care needs of eligible veterans in the Commonwealth of Puerto Rico and the Virgin Islands, as required by section 107 of Public Law 98-160.

Today's testimony, together with the VA's construction and leasing program budget submission, will assist the subcommittee and the full Committee on Veterans' Affairs in the development of its construction and leasing resolution required by section 5004(a) of title 38, United States Code.

This provision requires the committee to adopt a resolution approving major construction projects for each fiscal year prior to the appropriation of funds for these projects. Major construction is defined as "any project costing $2 million or more." We are also required to approve any lease which would cost $500,000 or more per year.

Members of the subcommittee have before them volume IV of the VA's budget submission for fiscal year 1985, medical construction and leasing. The Administration's construction budget request calls for $821.8 million in new budget authority, an increase of $290.7 million from fiscal year 1984. The program level of $941.8 million includes $120 million reprogramed from prior year appropriations and is the largest construction program level in VA history.

I have reviewed the construction program budget request, and am pleased to note that 10 new nursing home care units will be opened in the Bronx, N.Y.; Dallas, Tex.; Denver, Colo.; Fresno and West Los Angeles, Calif.; Washington, D.C.; Seattle and Spokane, Wash.; Wichita, Kans.; and Salt Lake City, Utah. This is good news for our rapidly aging veteran population.

Public Law 98-160, section 107, requires the Administrator to report to the Congress on his plans to meet the health care needs of veterans in Puerto Rico and the Virgin Islands. That report was submitted to the subcommittee on February 16, 1984. Public Law 98-105 which extended the special contract authority for medical care in Puerto Rico and the Virgin Islands for 1 additional year, expires on September 30 of this year.

In order to obtain firsthand information concerning the local health care delivery capabilities at these unique locales, certain staff members of the committee and subcommittee joined with their counterparts on the Senate Veterans' Affairs Committee to visit Puerto Rico and the Virgin Islands just last week.

Their briefing to me indicates that certain intermediate action should be taken in the near future to improve the quality of psychiatric care being given to Puerto Rican veterans in contract hospitals. While there is no mention of any such action in this recent VA report, I hope that the Chief Medical Director, Doctor Custis, might provide us with his short-term remedial action plans for Puerto Rico.

We will hear testimony from our colleagues, Balta Corrada and Ron de Lugo, regarding VA health care in Puerto Rico and the Virgin Islands. Before hearing their testimony I would like to recognize the ranking minority member of the subcommittee, as well as the full committee, the Honorable John Paul Hammerschmidt of Arkansas.

STATEMENT OF HON. JOHN PAUL HAMMERSCHMIDT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARKANSAS

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman.

We meet today to consider a very large and necessary Veterans' Administration construction budget. We know that a relatively new planning process has been used in its formulation. We know also that if that process lives up to its expectations, future construction budgets will be based on local grassroots information coupled with input at the district and regional levels. Final decisions will be made at the central office, taking total national needs into consideration.

Mr. Chairman, this same planning process will be used in decisionmaking with respect to resource allocations in VA's Depart-

ment of Medicine and Surgery. Hopefully, it will be of material assistance to Dr. Custis and the Administration.

In that connection, Mr. Chairman, we are very much aware of the difficulties in properly allocating and spreading limited funds to VA's very large and complex medical programs and facilities. The construction budget before us is a good example.

I am confident that most of our witnesses today will say some kind things about the budget while also expressing some beliefs and hopes with respect to certain projects not scheduled for fiscal year 1985.

In my view, Mr. Chairman, questions concerning Baltimore, Philadelphia, and San Juan are particularly valid. Baltimore has been justified over and over again and is ready to be built. In Philadelphia the need is great and VA stands to lose valuable donated land unless it steps up its timetable.

As to Puerto Rico, more needs to be said. We can conclude from VA reports to us that it knows the problem. And yet, Mr. Chairman, the budget before us barely attacks that problem and in essence tells us to wait on the planning process to completely work its will. The budget does contain money for a nursing home of 120 beds and a 10 bed blind rehabilitation unit. Both are probably needed, particularly the blind rehabilitation unit.

But as to the nursing home, a fundamental question arises: Is it needed more than the proposed new wing? The further question is: Would it be better to use money requested for the nursing home to begin the actual process for the new hospital addition? These are questions that I trust will be addressed this morning by Dr. Custis and his associates.

Mr. Chairman, the chairman of the full committee and you and I and our Senate counterparts have just received more dramatic and more disturbing reports about Puerto Rico. Our previous conclusions have been reinforced. I think we agree that both the executive branch and the Congress should move quickly to cure very serious difficulties on the island.

The VA medical center there is an excellent facility giving quality care. However, the overcrowding at San Juan, the lack of timely care of some seriously disabled, service-connected veterans, extensive contract outpatient care, the long waiting time for many needed examinations and treatment and the obvious understaffing of the hospital are each serious in their own right.

But, Mr. Chairman, they pale in the extreme by comparison to the contracted substandard treatment and outright lack of medical care given to a significant number of Puerto Rico's veterans, many of whom are service connected and rated as totally disabled. This is an intolerable situation and I am sure that both Dr. Custis and Harry Walters agree with my analysis and I would hope that we can all agree that something ought to be done and done quickly to correct the situation.

Mr. Chairman, the facts are not in dispute. The solutions are not in dispute. Let us hope then that this committee and the VA can translate these facts and those proposed solutions into a new funding timetable that will allow the veterans of Puerto Rico the medical care and the medical care and consideration that they so richly deserve.

Mr. EDGAR. Thank you, John Paul.

I would like to yield at this point to my colleague from Florida, Mr. Mica.

Mr. MICA. Thank you, Mr. Chairman. I would just like to ask permission to submit several questions for the record. I have a conflicting committee meeting at this very moment.

Mr. EDGAR. Without objection, so ordered.[1]

Are there any additional opening statements before we move to our first witness?

[No response.]

Mr. EDGAR. I would like to now call on the Honorable Balta Corrada, the Resident Commissioner from Puerto Rico. We are very pleased to have you here today. Balta, before you begin, I would like to thank you and your staff for the cordial welcome that you gave to our staffs as they went to Puerto Rico just in the past week to take a look at the issues which you are going to raise in your testimony. I would like to congratulate you for that help.

Mr. HAMMERSCHMIDT. Mr. Chairman, if you would yield. May I join you in welcoming our very distinguished friend and witness.

STATEMENT OF HON. BALTASAR CORRADA, RESIDENT COMMISSIONER OF PUERTO RICO

Mr. CORRADA. Mr. Chairman and members of the subcommittee, I am pleased to appear again before you today. My testimony consists of eight pages which I request be made part of the record.

Mr. EDGAR. Without objection, your full statement will be made a part of the record.[2]

Mr. CORRADA. I would like to, of course, express my deep appreciation for the statements and remarks made by Chairman Edgar and ranking member, Mr. Hammerschmidt, and for their sensitivity concerning the health care needs of veterans in Puerto Rico.

Mr. Chairman and members of the subcommittee, I appreciate the opportunity to appear before you today to address the pressing need for the VA to develop a comprehensive plan leading to the offering of adequate health care to every eligible veteran in Puerto Rico.

At the outset, I want to thank Chairman Edgar and the ranking minority member, Mr. Hammerschmidt, for the interest they have placed in assessing and solving the deficiencies in the VA health care delivery system on the island, which has been recently evidenced by the bipartisan subcommittee's staff visit to Puerto Rico.

I also want to thank those who made the trip, namely, Jack McDonell, Rufus Wilson, and Richard Fuller for the concern and sensitivity they displayed throughout their visit as well as their eagerness to learn more about the VA system on the island.

In my testimony today, I will refrain from once again burdening this subcommittee with the facts and statistics which fully justify an aggressive and coherent initiative by the VA and Congress to remedy the deficiencies in the VA health care delivery system in Puerto Rico.

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[1] See p. 67.
[2] See p. 57.

Nevertheless, I will once again call your attention to the 1978 GAO report which portrayed the VA health care delivery system in Puerto Rico in urgent need of additional resources to enable it to deliver proper medical attention to eligible veterans there and which was dependent on private suppliers of health care which, in the area of psychiatric care, offer inadequate facilities and services in most cases and below the standards of the VA in the others. As you know, these findings were ratified by the VA in two separate reports to Congress presented in April 1981 and January 1983 and most recently in February 1984, and currently remain unchanged.

I was certainly pleased to see the inclusion in the VA budget for fiscal year 1985 funds for the construction of a 120-bed nursing home and a 10-bed blind rehabilitation center in Puerto Rico which I am confident Congress will approve.

Presently there are no VA nursing homes, on the island and the VA contracts 50 beds for our senior veterans. There are 13 non-VA nursing homes on the island with a bed capacity of 987 of which all but few are below VA standards. This means that there are 5.9 beds per 1,000 inhabitants over 65 years of age in Puerto Rico as compared to 65.9 beds per 1,000 persons over 65 years of age on the U.S. mainland. In 1980 there were 13,000 veterans over the age of 65 in Puerto Rico and by 1990 it is estimated that this number will soar to over 33,000 elderly veterans which fully justifies, of course, the action taken by the VA in requesting the 120-bed nursing home.

However, I am concerned, of course, that still there is no proposal about the construction of a 480-bed psychiatric wing in the VA medical center in Rio Piedras, an outpatient clinic for the southern part of the island and the expansion of the outpatient clinic in Rio Piedras which are also critical for the VA to be able to offer quality health care to all eligible veterans on the island as fully justified in the previous reports that I mentioned to you.

A comprehensive plan needs to be enacted if the veterans in Puerto Rico are to receive quality health care by the end of the decade. The VA health care delivery system on the island is 20-percent underfunded and 20-percent overworked. The bottom line, Mr. Chairman and members of the committee, is that the veterans in Puerto Rico have never received in the past, are not receiving in the present, and if something is not done promptly, will not for many years to come receive the quality medical attention they have so rightfully earned.

I would also like to address today a situation which has caused me great concern and which should be of concern to the members of the subcommittee, particularly in your responsibilities as full committee members, although perhaps not directly related but indirectly related to the construction situation and that is that I have recently learned that the VA is assigning rating jurisdiction in psychiatric claims from Puerto Rico to the Winston-Salem regional office.

New and reopened claims and claims for increased evaluation of psychiatric disabilities would be subjected to this new procedure which also includes a review for acceptance of the report of examination by the VA central office prior to being sent to the Winston-Salem regional office for rating.

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I understand that what triggered the new rating procedure is the fact that in Puerto Rico there are 2½ times as many veterans service-connected for psychiatric disabilities than in the rest of the country and four times as many rated totally disabled for these disabilities.

Even though I believe that fraud, abuse, or errors in any Federal program should be eliminated where they exist, I object to the new rating procedures. I believe this new procedure is discriminatory, ill-advised, and open to challenges for due process violations.

Statistics in this case reflect a disparity between U.S. mainland veterans and Puerto Rican veterans, but do not necessarily indicate that such disparity is based on fraud, abuse or error. The higher incidence of mental health problems among Puerto Rican veterans portray the reality that these veterans, given the different culture, idiosyncracy, lifestyle, and language, coupled with the economic distress of the island and the extreme population density of Puerto Rico, suffer from conditions that bear heavily on their mental health.

First, mental health problems occur at a higher rate in Puerto Rico than on the U.S. mainland not only among veterans but also among nonveterans. This has been attributed, in part, to the overpopulation the island experiences. Our population density of approximately 940 persons per square mile is by far higher than that of any State except for New Jersey.

Just to illustrate this point, the population density of Puerto Rico is 940 persons per square mile. The population density of the U.S. mainland is less than 80 persons per square mile. If we brought to the U.S. mainland the entire population of Mexico, of all the countries in Central and South America, of all the countries in Europe, in Africa, in Asia, the United States would have a population density of 1,000 persons per square mile, which is about what Puerto Rico has now—940 persons per square mile.

I wonder that if we brought the population of the entire world here as well as all the stress it brings about if U.S. mainland veterans would reflect a higher incidence of mental health problems as do the veterans in Puerto Rico. I venture to say that not only veterans but also most nonveterans would be reflecting problems of mental health created by such a population density.

Second, Puerto Rican veterans not only have to contend with the horrors of war and its lingering effects but also with the cultural shock, their lack of proficiency in English language precipitates. The language barrier also precludes the Puerto Rican soldier from assuming skilled positions in the Armed Forces, forcing the vast majority to become infantrymen, a position which demands a higher degree of sacrifice and stress.

In addition, the Puerto Rican veteran, also due to his general lack of proficiency in English, is normally precluded from fully benefiting during times of war from the highly helpful counseling program which is usually offered in English.

Third, mental health services are available to veterans from other sources in the U.S. mainland, but such services are very limited in Puerto Rico. A major factor contributing to this situation is that medicaid applies to Puerto Rico on a very limited basis with

the Federal Government providing a cap of $45 million while the Puerto Ricán government provides over $148 million.

Furthermore, with a level of unemployment in excess of 20 percent and many others underemployed, Puerto Rican veterans do not have the same access to private health insurance programs paid by their employers which could also be a source of treatment for mental health problems, but in the case of Puerto Rico the only resource many veterans there have is going to the VA for treatment.

Fourth, the law requires that if a veteran is hospitalized for service-connected psychiatric reasons for a period of at least 6 months, the veterans' claim for a 100-percent disability rating must be approved. As it is well known to the subcommittee, approximately 70 percent of the inpatient psychiatric care in Puerto Rico is contracted with institutions that offer services and treatment well below the VA standard and with lengths of stay at least four times that of the VA hospital in San Juan, precisely due to the lack of sufficient VA medical facilities for these psychiatric cases.

I believe this situation could be solved by having the VA assume full control of all psychiatric cases through the construction of a psychiatric wing in the San Juan area. This will assure the VA that proper treatment modalities are used in every case and, therefore, overextended stays would be eliminated.

Another concern I have regarding the new rating procedure is that they lack the guarantees of due process the regular procedures have. The new procedures require the board in San Juan to only conduct a hearing with no further involvement in the decisionmaking process and then the case would be transferred to Winston-Salem for a rating board there to make a final decision based on the record of the hearing that they never attended.

The basic principle of due process would be shattered. This principle calls for a day in court for every claimant offering him or her the opportunity to argue his or her case before the persons judging the same as well as giving the person the opportunity to answer any concerns or questions the judges may have. In addition, the hearing record would have to be translated and thus the impact of the testimony could be weakened or misinterpreted.

Also the rating process would be substantially delayed. Through these new rating procedures, the veterans in Puerto Rico would be surrendering highly important rights and will never face the real judges of his or her claim. In addition, these new procedures seriously question the capacity of the rating board in San Juan to make sound decisions at a time when its record of allowed and disallowed appeals before the Board of Veteran Appeals is similar to that of Winston-Salem. By singling the San Juan rating board for this new procedure, its credibility, to say the least, could be weakened.

Mr. Chairman, in closing, I urge you to join my efforts to reverse the VA decision establishing temporarily new rating procedures for Puerto Rico or to terminate new procedures immediately and I further urge you to continue to promptly secure a comprehensive plan from the VA leading to the offering of the quality health care every needy eligible veteran in Puerto Rico has earned.

I appreciate, of course, the opportunity you have granted me today.

Mr. EDGAR. Thank you. I really appreciate your comprehensive testimony and it fits in with the information that we received from our staffs and their visit.

On the issue of the new rating system, we will make sure that your testimony is given to the staff and the chair of the Compensation and Pension Subcommittee who is looking into that particular rating problem. It's not under the jurisdiction of this particular subcommittee, but it is, as you indicate, an important question and it needs to be resolved.

About a year ago we passed legislation to only give the VA a 1-year extension of their contract authority. They were seeking a 3-year extension of that contract authority for Puerto Rico and the Virgin Islands, primarily because the long-term solution of a psychiatric wing and other facilities to meet the needs of veterans in Puerto Rico would take some time in the planning and development.

We decided to give only a year's extension and review it on a year-by-year basis to keep a maximum amount of pressure on the Office of Management and Budget and the VA to come up with that permanent solution, given the data that you had provided and others had provided over the years, and also given the information that the VA itself had determined in terms of their long-term needs.

It looks at this point as though that long-term solution is in the works but is coming down the line several years out. I wonder if you have any specific solutions for what might be termed the interim solution. Are there ways in which you would suggest that we handle the psychiatric needs of Puerto Rico as well as the other health care needs of Puerto Rico in the short term?

Mr. CORRADA. Well, it appears, Mr. Chairman, that, frankly, in the absence of an expansion of the facilities there to provide for psychiatric beds that definitely there would be a pressing need on the part of the VA who have authority to continue to contract out services for these veterans with private suppliers. But I would again support that instead of extending that period for 3 years, that you extend it solely for 1 year again, forcing both the VA and OMB to take a hard look at how they can accelerate this process.

Frankly, the interim solution that I see is just seeing how the VA could accelerate the construction of the 480-bed psychiatric wing in Puerto Rico.

Mr. EDGAR. Let me just make one final comment which I need your help on and that is, assuming that we do that, a 1-year contractual relation, it's my information that the quality of some of the contract care is very poor and there is some question as to whether or not the VA is able or has been able to exert enough quality control over the contractors rather than keeping veterans in prison-like conditions giving some sensitive direction as to how to give better quality care in Puerto Rico.

It would be helpful if you and your staff could begin to think about ways, knowing Puerto Rico as you do, that we could improve that contract care in the short term. I just have some real frustration, given the reports that I have been given, about that quality

and I am nervous about the VA getting a very bad reputation by contracting out services to contractors who aren't providing the kind of human quality of care that needs to be provided.

Mr. CORRADA. Well, certainly, I don't see why currently the VA could not exert more pressure on those suppliers to make sure that they improve the quality of the service that is rendered under a contract which signifies a substantial amount of income for these institution. From the standpoint of management, I do believe some improvement could be done. In that respect, I will certainly look into possible suggestions that we may have to you and your staff concerning those possibilities.

Mr. EDGAR. Thank you.

Are there questions?

John Paul?

Mr. HAMMERSCHMIDT. I have no questions, but I want to thank Balta for his very fine and comprehensive testimony and to assure him that as the ranking member of the full committee and as a member of the subcommittee that would handle the oversight of that new rating procedure that your testimony will receive full consideration of course, Balta.

I yield to the distinguished gentleman from Indiana, Mr. Hillis.

Mr. HILLIS. I, too, have no questions, but I just wanted to join in the remarks of my colleague, John Paul Hammerschmidt. Your testimony will be taken very, very seriously by me and I am sure all of the members of the subcommittee. It's been very worthwhile to have you with us.

Mr. CORRADA. Thank you.

Mr. EDGAR. Dr. Rowland.

Dr. ROWLAND. Thank you, Mr. Chairman. I also want to thank you for this very excellent testimony. What is the ratio of physicians to population in general in Puerto Rico and could you comment on the quality of medical care in general there?

Mr. CORRADA. Well, the population in Puerto Rico is 3.2 million inhabitants. Approximately 60 percent of the population is considered to be medically indigent, which creates a tremendous pressure on the public health service system on the island. Medicaid does not fully apply in Puerto Rico—it applies under a cap placed by Congress of $45 million per year since 1981 when it was increased from $30 million to $45 million. If medicaid was fully funded in Puerto Rico, it is estimated that that amount should be approximately $200 million. The burden that this 60 percent of our population poses on our health system which—of course—includes veterans because they fall within the full spectrum of low-income, middle-income, high-income people there, coupled with lack of sufficient funds creates a public health system that is below the standards of those we have here in the U.S. mainland.

A veteran in the U.S. mainland may go to the public health system or, in the case of those who are employed, may have private health insurance which covers health care in private institutions. In Puerto Rico with the situation of high unemployment plus the inadequate public health system, we have a situation where veterans to find the kind of health service that they, as U.S. veterans feel that they deserve, resort to the Veterans' Administration

health care services to a larger degree than a veteran in the mainland. It is human that it be that way.

We are trying and pushing right now for an increase in the medicaid fund for Puerto Rico. As a matter of fact, the House already passed an increase of $30 million in the health care for the unemployed bill, but that's stuck in the Senate and the chances of the measure passing are not very good.

Basically that's the situation.

Dr. ROWLAND. The population is about 3.6 million, did I understand you to say?

Mr. CORRADA. 3.2 million according to the 1980 census. Now in 1984 it's approximately 3.3 million.

Dr. ROWLAND. Do you know how many physicians there are in Puerto Rico?

Mr. CORRADA. I will submit it to you.

Mr. EDGAR. Without objection. If you could supply that for the record, please, Balta.

Mr. CORRADA. I will supply that for the record.

[The information follows:]

In 1980 there were 4,057 physicians in Puerto Rico. 1,607 of these physicians were general practioners and 2,450 were specialists—58 percent of all physicians on the island worked in the public sector and 42 percent in the private sector.

Dr. ROWLAND. The point is, on the mainland we have 1 physician for about every 632 people and the ratio may be much different in Puerto Rico.

Mr. CORRADA. The ratio there is higher and I will submit later information to the committee concerning that.

Dr. ROWLAND. I thank the gentleman.

Mr. EDGAR. I think there are two points. One is the ratio of physicians to the population and the second is that with health care needs as they are in Puerto Rico, the VA takes on an added role of being that hospital of last resort for the island.

Dr. ROWLAND. Exactly.

Mr. EDGAR. Are there other questions or comments for this witness?

Mr. Bilirakis?

Mr. BILIRAKIS. Mr. Chairman, just very quickly, I, too, would like to thank our colleague from Puerto Rico for his very good statement. I certainly learned a lot. I think the real point here and the foundational point is that the men and women of Puerto Rico that served in the U.S. Armed Forces sacrificed every bit as much as those of us from the mainland and it is important that we treat them on an equal basis. Apparently that hasn't been the case up to now.

Mr. CORRADA. We are very proud to serve in the U.S. Armed Forces. Puerto Rico not only provides, of course, manpower to our armed services, but we do also provide very vital strategically facilities for our national security, such as the Roosevelt Roads Naval Base in Puerto Rico, which is the largest naval station in the world, and which provides the most important training site for the Atlantic fleet. Also, because of its location it provides vital support for security of important maritime routes, including routes that

comprise over 50 percent of all the oil that comes to the United States.

Mr. EDGAR. Are there additional questions?

Mrs. Johnson?

Mrs. JOHNSON. I too want to thank you for your very good testimony. I think it highlights a couple of things that I would like to comment on. I don't know the answer to them, but I think they set in context some of the things that this committee has to deal with.

First of all, I know in my own facility in Connecticut the issue of service-related and nonservice-related has become a major issue. The veterans that I represent that have a service-connected disability of any kind are receiving treatment—good treatment and prompt treatment. Those whose disabilities or health problems are not service-connected may or may not be receiving treatment.

Now I appreciate that many of them probably have better private sector health insurance support for those things than do the veterans in Puerto Rico, but your statistics on the psychiatric needs of veterans indicate very clearly that what we are dealing with is a veteran population whose psychiatric problems spring either as much or perhaps more from the society in which they are living than from their military service. That doesn't in any way relieve us of responsibility, but I wonder whether you have any statistics as to what portion of the psychiatric problems appear to be service connected.

The second thing is, has there been any attempt, not so much on your part, but on your part in cooperation with others in leadership positions in Puerto Rico and the United States, to determine how money invested for veterans could be better used to improve the quality of the health system for the whole island, because, clearly, a lot of their problems are island problems. With 60 percent of the population medically indigent, I think we have to be careful about in the end building one sort of quality of life and lifestyle and support system for a percentage of the population, whether or not their disabilities were service connected and creating, in a sense, a two-class society based on veteran service.

If we do for them what needs to be done and we don't do for the rest of the population what needs to be done, then we are going to create a system that we are not going to be proud of. We might be proud of it for veterans, but we are not going to be proud of it as Puerto Rican Americans or as mainland Americans.

I wonder if we shouldn't be looking at: How can VA investments be made? Maybe the best thing isn't building a psychiatric wing. Maybe the best thing is to take that money and build outlying clinics in which veterans would get preference, but which would be open also to the local populace.

Now, I realize I am raising much bigger questions here than we can possibly solve, but I find inadequate the framework in which we are viewing the veterans' problems in Puerto Rico and I think, from our point of view of dealing as we do day-in and day-out with the conflict between service-connected access and non-service-connected access, what information can you give us about, first of all, service-connected nature of disabilities, both physical and mental versus non-service-connected?

Mr. EDGAR. Would the gentlewoman yield?

Mrs. JOHNSON. Yes; I sure would.

Mr. EDGAR. I appreciate the context of the gentlewoman's question and I await Balta's response. I think that your question needs to also be raised with the chief medical director. In order for us to proceed with the hearings, I am going to have to ask Balta to be brief in his response so that we can move to the next witness and then move to the chief medical director, but I think the question clearly has to be answered.

Mrs. JOHNSON. I agree, Mr. Chairman. I am really not asking now for a long answer. It is just that those facts are most important.

Mr. CORRADA. First of all, on the question of a determination of a disability resulting from mental health problems, obviously in the case of Puerto Rico, like in any other case, a finding has to be made that the mental health problem to be service connected must be related to service in the Armed Forces. A veteran may have a mental health problem in Puerto Rico and many do, but if it's not service connected, then they do not get compensation for it. They may be eligible for certain kinds of treatment.

But let me point out that the fact that there is, generally, in the environment because of the population density, poverty and other factors, a situation which could create more mental health problems. Therefore, when a person from that part of the United States is inducted into the armed services and taken to war, a latent mental health problem may be exacerbated or may surface. Whereas if you come from an environment where you don't have this level of stress then when faced with the situation of war, then you will probably be able to cope with the mental stress the war precipitated.

So it may be service-connected because it was service in the Armed Forces that exacerbated or created or made the problem come afloat although it was latent.

Second, concerning, your remarks regarding two types of health care services, I couldn't more fully agree with you, but the solution is not saying, "Well, since everybody else is getting lousy medical service, make sure that it's uniform and let's give lousy medical service to the veterans." I think the answer to that question is: What can be done to improve overall medical care in Puerto Rico and I think the answer to that question is, obviously, that higher funding of medicaid is essential as well as higher funding by the Commonwealth government of the health care system on the island possible when our economy improves. Also, when more people are employed and we are involved, of course, in an economic development program, their health insurance plans will help alleviate the burden on the public health care system in Puerto Rico and thus make it more accessible to more people as well as enable the local government to improve the quality of care there.

Mr. EDGAR. Thank you.

I thank the gentleman for his testimony this morning and I appreciate the comprehensive nature of it. We will continue to pursue questions that are raised by your testimony with Dr. Custis.

Mr. CORRADA. Thank you very much.

Mr. EDGAR. Our next witness will be the Honorable Ron de Lugo, the Delegate from the Virgin Islands.

Before you begin your testimony, I would like to thank you and your staff for the gracious welcome and care that you gave the staff of the Veterans' Committee as they visited the Virgin Islands just last week. We appreciate that support.

I am going to yield the chair to my colleague from West Virginia, Mr. Mollohan, for a few moments while I make a telephone call. I apologize for leaving at this point.

The full text of your statement will be made a part of the record, without objection.[1]

STATEMENT OF HON. RON de LUGO, DELEGATE FROM THE VIRGIN ISLANDS

Mr. DE LUGO. Thank you very much, Mr. Chairman. Before you leave, the real reason that I came by—I am going to submit a prepared statement—is to thank you and this committee for having sent staff down to the Virgin Islands. I think it was a very helpful, constructive visit.

Mr. EDGAR. I appreciate that. You may proceed with your testimony.

Mr. DE LUGO. Mr. Chairman, I will submit a prepared statement for the record. I join with my colleague, Baltasar Corrada, in his statement. There is a tremendous need for additional help for the veterans in Puerto Rico and if that need exists in Puerto Rico, it also exists in the Virgin Islands, because in many cases, the Virgin Island veteran has to go to Puerto Rico to seek certain types of medical assistance.

With the help of this committee, the medical needs of the Virgin Islands veteran—and here I might point out to you that these offshore areas such as Puerto Rico, the Virgin Islands, and Guam have a higher ratio of their citizens serving in the armed services on a voluntary basis than most other areas—in fact, I think, more than just about every other area on the mainland. So there is no question that we have a real debt to these veterans that has to be met.

This committee has helped us to improve the medical care that the Virgin Islands veterans are receiving. Until a few years ago, Virgin Islands veterans had to catch a small plan and go to Puerto Rico to get practically any medical help that they could. Since that time we have established the contract fee service in the Virgin Islands and that's working well.

Basically, the real needs of the Virgin Islands veteran fall in another area, and that is the veteran getting counseling and assistance as to his or her benefits, such as housing benefits and VA loans. We've been very remiss on that in the Virgin Islands.

And it is in this area that I want to commend the committee for having sent down a very able staff member, Richard Fuller, and also from the VA, Alan Jones just last week. And out of that meeting that was held in St. Thomas with the veterans there and the veterans from the island of St. Croix, came the decision to establish on the island of St. Croix an outreach office for veterans. This had not existed up to this point.

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[1] The prepared statement of Hon. Ron de Lugo appears on p. 59.

And it also became clear to the staff and to the representative of the VA that the Virgin Islands veteran really needed some help in counseling, as to how to get his benefits. He needed someone there who could issue certificates for his benefits. And this outreach office that will be established will meet this broader need.

There are three additional needs that I hope that as the committee sees the opportunity, will give support to in the months and years to come for the Virgin Islands veteran.

You have heard Commissioner Corrada point out to you the tremendous burden that the VA is—the tremendous need that exists in Puerto Rico. Well, we are very close to our Puerto Rican veterans and very close as a people, and we're good neighbors. But when a Virgin Island veteran goes to Puerto Rico, it is just human nature that with this tremendous need in Puerto Rico, the Puerto Rican veteran is considered before him. And we have had some difficulties there.

One of the things that we feel we need in the VA Center in Puerto Rico is an ombudsman for the Virgin Islands. We need, in the Virgin Islands, an outpatient clinic and we need a VA benefit office. I think that the need will be met to a certain degree by an outreach office, which is now being established.

With that I want to again thank this committee for its assistance, and I will submit a prepared statement.

Mr. MOLLAHAN. Thank you for that statement.

Any questions?

Mr. HAMMERSCHMIDT. I just want to thank Ron for coming by and making his remarks. Also, we'll examine your more comprehensive testimony, Ron.

We recognize, and the VA recognizes, that there are unique aspects of health care planning in Puerto Rico and in the Virgin Islands. We will take that into consideration in our deliberations. Thank you very much, Ron.

Mr. DE LUGO. I want to thank the committee again.

Mr. MOLLOHAN. Thank you. I'd like to recognize the chairman's presence and welcome him and thank him for coming.

Mr. MONTGOMERY. Thank you, Mr. Chairman, and Ron, we're glad to have you here before this committee, and we certainly will take what you said and consider it. We are concerned about the different islands and territories and I guess this committee has spent as much time as any committee working in that area of seeing that the veteran is treated fairly and that the facilities are there to take care of the situation.

I might just want to comment on Puerto Rico, Mr. Chairman. We've been concerned that there have been more service-connected veterans declared 100 percent, percentagewise, than in the States, and this action that we're taking in Puerto Rico is temporary, but if there are abuses of the program, they should be corrected. And as chairman, I'll push ahead to be sure that people are not getting on the rolls, being classified as 100-percent service-connected veterans, when they don't deserve to be there.

If you want to kill a program, the best way to kill it is to put people on there that are ineligible. And it is not aimed at picking on any one individual territory or State, and it is temporary, but where we have abuses in these programs, they ought to be correct-

ed. As chairman, I'm certainly going to push ahead to see that all veterans are treated fairly and none get more advantages than others.

Thank you.

Mr. MOLLOHAN. Thank you, Mr. Chairman.

Any other questions?

Ron, thank you very much for your testimony.

Mr. DE LUGO. Thank you, Mr. Chairman.

Mr. MOLLOHAN. Our next witnesses are Dr. Donald Custis, Chief Medical Director of the Veterans' Administration, accompanied by a panel. Will you please come forward to the witness table?

I'd like to welcome you to the hearing today. I appreciate the testimony that you're going to give. Any written statements will, without objection, be made a part of the record, and you might proceed by introducing those who are with you today at the witness table.

STATEMENT OF DR. DONALD L. CUSTIS, CHIEF MEDICAL DIRECTOR, VETERANS' ADMINISTRATION, ACCOMPANIED BY MAX R. WOODALL, DIRECTOR, COMPENSATION AND PENSION SERVICE, DEPARTMENT OF VETERANS BENEFITS; CHARLES FREEMAN, DIRECTOR, VA HOSPITAL, SAN JUAN, P.R.; WILLIAM F. SULLIVAN, ASSOCIATE DEPUTY ADMINISTRATOR FOR LOGISTICS; AND WILLIAM A. SALMOND, DIRECTOR, OFFICE OF CONSTRUCTION

Dr. CUSTIS. Thank you, Mr. Chairman.

With me at the table are Mr. Woodall, the Director of the Compensation and Pension Service of DVB; Mr. Charles Freeman, our Director at the VAMC, the VA Hospital in San Juan; Mr. Bill Sullivan, the Associate Deputy Administrator for Logistics; and Mr. Salmond, the Director of the Office of Construction.

Mr. Chairman and members of the subcommittee, we are pleased to appear before you this morning to present the Department of Medicine and Surgery's medical facility construction request for fiscal year 1985.

Before describing the fiscal year 1985 construction program and its development, I would like to reference the magnitude of the VA health care system and the construction planning environment. As you know, the VA health care system is made up of 172 medical centers, 101 nursing home care units, 16 domiciliaries, and 53 independent and satellite outpatient clinics.

The system operates in over 5,000 separate buildings, with over 100 million square feet of space. We have tremendous capital investment represented by these buildings. However, the investment is aging. Over 53 percent of our hospital beds are in buildings that are over 30 years old. The majority of our VA medical centers were constructed without the capability to expand to meet the increasing need for outpatient care.

Construction standards used did not reflect the requirements stipulated in today's safety codes, nor did they sufficiently provide for a barrier-free architectural design for the handicapped patients.

While improvements to the physical structure of these buildings have been made in the past, a great deal remains to be done. Our capital improvements program must also provide facilities to respond to the changing needs of our veteran population, an aging population that is rapidly migrating to the Sun Belt areas of the country.

The construction budget request for medical projects includes a major construction program level of over $730 million. This reflects $120 million in reprogramings from prior appropriations, made available because of the favorable bidding climate the construction industry has been experiencing of late.

Under the major programs, we are requesting approval for 53 new construction projects, additional funding for 1 project, $17 million for the advanced planning fund, $25 million for asbestos abatement projects, and $5.2 million for energy conservation projects.

This major program request also includes a proposal to initiate a design fund. This design fund will enable the VA to proceed directly into the working drawing phase of construction project development, thereby saving a significant amount of money associated with the current delay between completion of preliminary drawings and working drawing contract award for a project.

The estimated savings from reduced inflation and design changes alone will be $34 million in fiscal year 1985. Our minor construction program request for medical projects is $149 million. We expect to fund approximately 60 minor projects in the range of $400,000 to $2 million in estimated costs, and 200 minor miscellaneous projects in the range of $100,000 to $400,000.

An extremely important factor in determining the projects to be included in the fiscal year 1985 major construction request was the impact of the medical district-initiated program planning process. This process, initiated in 1981, completed its first full cycle in the spring of 1983. This grassroots planning process provides for a comprehensive assessment of current capability to meet future demand for health care services and includes plan strategies for meeting that future demand.

The heart of this planning effort is a valid analytic base which projects program needs in the future and supports resource allocation efforts to achieve these program goals. MEDIPP projections of inpatient and outpatient workloads, mission changes, and new program requirements provide primary input to the construction planning process.

Because of the lead times associated with major construction projects, those in the 1985 budget were being developed before the first MEDIPP plans were approved. Thus, the 1982 MEDIPP cycle provided for the validation of programmatic requirements used in the development of each major construction budget.

Analysis showed that all projects in this budget request were supported by the MEDIPP data. The VA's fiscal year 1986 construction budget request will be more specifically or more significantly impacted by the MEDIPP process, because the MEDIPP programmatic requirements will have been used from the beginning of the development process for these construction projects.

To repeat, the full impact of MEDIPP will be visited upon the 1986 budget.

We know of the committee's concern for meeting the health care needs of the eligible veterans in the Commonwealth of Puerto Rico and the Virgin Islands. The VA is proposing in the fiscal year 1985 request to construct a 120-bed nursing home care unit and a 10-bed blind rehabilitation center at the VA medical center in San Juan.

In addition, we plan to continue to contract nursing home care beds for an average daily census of 50. Preliminary steps toward the acquisition of an outpatient clinic in Ponce are also underway.

Medical district No. 3 including the medical center in San Juan, submitted their MEDIPP plan in November of last year. Although many needs identified in the MEDIPP submission are supported with quantitative justifications, plans to implement improvements in Puerto Rico must compete with all others for funds. Results of the central office review of the 1983 MEDIPP district plans will be completed in may

The specific resource needs in Puerto Rico and the Virgin Islands will again be evaluated in the light of the needs determined through MEDIPP for all other hospitals and health care delivery programs within the VA system.

Mr. Chairman, in closing, the fiscal year 1985 construction program represents a corrective and improvement effort that is vital to the VA's health care delivery system. We appreciate your continued support and your effort to provide for the health care needs of our Nation's veterans. We'd be pleased to answer any questions that you may have.

Mr. EDGAR. Thank you very much for your testimony and we will have a number of questions for you. I appreciate the thoroughness of your statement, and the documentation that you've provided us.

Dr. Custis, let me begin with just a couple questions about the problems in Puerto Rico and the Virgin Islands. Then I'll yield to my colleagues and then come back with a large number of specific questions that I personally have for you.

In your statement you talk about the nursing home facilities, the blind veteran facility, for San Juan. You make no mention of any interim plans on—in terms of the contracting out of psychiatric care and psychiatric service.

Some of our staff visited some of the contracted services and felt that the quality of that care was not as high as it really should be. Do you have any personal feelings, feelings that your agency could assist in improving the quality of that contracted care?

Dr. CUSTIS. First of all, Mr. Chairman, I certainly agree with the appraisal of the quality of contracted care that the committee has expressed. There are several things that are currently being done to serve us over the short term. This is not a solution but it is an effort to improve what, of necessity, is going to have to continue under contract until such time as the facilities the VA has in Puerto Rico can absorb the full demand for care.

Rather than stealing his thunder, I would like to defer to Mr. Freeman, the Director, for him to explain directly what he is doing along these lines.

Mr. EDGAR. Mr. Freeman?

Mr. FREEMAN. Thank you, Dr. Custis. Mr. Chairman, it's a pleasure to be here.

The contract hospital has been my number one headache since I have been in Puerto Rico.

Mr. EDGAR. Would the gentleman talk into the microphone, because it's difficult to hear you here.

Mr. FREEMAN. I'm sorry.

We have taken some steps to try to get better control of the contract hospitals. Last August we formed a psychiatric intervention clinic at the hospital. I gave this program a 6-month probation to see if they could cut down on the admissions to the hospital, as well as to the contract hospitals.

Since August, we have eliminated some 80 beds in the contract hospitals. We were running a census of 501 and are now at 426 in the contract hospitals.

What I have proposed to Dr. Custis, what we discussed this morning, is that we continue this psychiatric intervention clinic. It is cutting back on admissions to the hospital and to the contract hospitals. Also, I'm proposing that we expand the hours of this "PIC" unit, as we call it. At the present time the clinic functions from 8 to 4:30.

Mr. EDGAR. Will the gentleman yield at that point? How do you fund that clinic that you're talking about?

Mr. FREEMAN. Out of our operating budget, sir.

Mr. EDGAR. Out of your operating budget?

Mr. FREEMAN. Yes, sir.

Mr. EDGAR. So you're really cannabalizing other parts of the hospital in order to fund that special clinic?

Dr. CUSTIS. If I may intervene here, Mr. Freeman, Puerto Rico did receive a nonrecurring increase in funding last fiscal year. Under the DRG program there's a reflection of very good productivity in Puerto Rico and their prospects for additional funding are very good, based on the modeling we're using for resource distribution.

Mr. EDGAR. Mr. Freeman?

Mr. FREEMAN. Plus, Dr. Custis and I have discussed this prospect of some additional funding and ceiling to continue this function.

So, what we want to do is expand the psychiatric intervention clinic and increase the hours of operation. I have already instructed the chief of the psychiatry service to recruit a full-time psychiatrist and a full-time administrative person whose sole responsibility will be to monitor the contract facilities. Their day to day responsibilities will be to work with the patients in the clinic, in the contract hospitals, as well as in our hospital PIC unit.

Also, it's in our plans to expand our ambulatory outpatient psychiatric care. I feel that this is an area where more services are needed and which may lead to less patients being warehoused in some of the contract hospitals.

Mr. EDGAR. Do you have the funding to do that?

Mr. FREEMAN. We're discussing it with central office.

Mr. EDGAR. What is the status of the VA/Department of Defense medical sharing agreement in Puerto Rico? What types of services do you share with the Defense Department? I mean in terms of beds, outpatient services, medical support.

Mr. FREEMAN. Because of the limited military resources for hospitalization at the Roosevelt Roads Navy Hospital, we do have to

take all their emergency cases. All their neurology cases also have to be referred to us because they just don't have the specialty there.

We do take, also, the emergency cases from Fort Buchanon.

Mr. EDGAR. But they're paying for that care?

Mr. FREEMAN. Yes; they reimburse us.

We're in the process of negotiating a sharing contract, so that these funds, once they are paid, will be left at the VA hospital in Puerto Rico instead of coming back to the central office.

Mr. EDGAR. Dr. Custis, if I could just ask you one final question in this area—I'll have other questions that I'll submit for the record—congressional interest in the VA health care delivered in Puerto Rico and the Virgin Islands dates back several years. You will recall last year's discussion where the administration came up and asked for a 3-year extension of contract services. We gave a 1-year extension, hoping to put some pressure on.

Study upon study has been done by the VA and the GAO and the IG about Puerto Rico, and after a 57-page report, the VA sent us in January of last year, it was our impression that certain plans to improve the hospital in San Juan would be forthcoming. The report we received last week states that you will have to wait for data from the November 1983 MEDIPP report.

Why is it taking so long to come up with the plans for solving the problems in Puerto Rico? Is last year's report still valid? And which of the three alternatives for acute care have you selected out of that report?

Dr. CUSTIS. What was the last part of the question, Mr. Chairman?

Mr. EDGAR. There were three alternatives for improving acute care in Puerto Rico, and I wondered if you had selected any of those three options.

Dr. CUSTIS. Regarding, the first part of your question, the fact that the clinical addition to the hospital in Puerto Rico is not in the 1985 budget is not based on a delay waiting for the MEDIPP process. It is that it did not make the grade in competition with other acute demands for hospital major construction.

In the meantime, as the 1986 budget is put together MEDIPP input will be available and permit a modification of the previous years' MEDIPP needs definition to be considered in the context of the 1986 budget.

The answer, I think, to the latter part of your question, is in the report that I have before me that was sent to Congress.

Mr. EDGAR. Why don't you submit that for the record, the response, that last part.

[Subsequently, the Veterans' Administration furnished the following information:]

The Agency completed a major study in 1981 and 1982, and an update of the 1982 study was recently released. VA planning must take into account the importance of balancing pressing needs in Puerto Rico and the Virgin Islands with equally-pressing needs in other locales, such as burgeoning demands experienced in Florida and other Sunbelt areas. This factor, along with the need to maintain quality health care facilities throughout the entire nation, requires that the results of all VA Medical Center and Medical District planning within the VA be evaluated by the Central Office. The District plan which affects Puerto Rico and the Virgin Islands, as well as

plans from all Medical Districts, are currently being reviewed. The results of this review will be used in formulating the Agency's budget request for fiscal year 1986.

The 1984 Report to Congress on Health Care Needs in Puerto Rico is attached.

REPORT ON THE HEALTH CARE NEEDS OF VETERANS IN THE COMMONWEALTH OF PUERTO RICO AND THE VIRGIN ISLANDS—PREPARED BY THE VETERANS' ADMINISTRATION (PURSUANT TO PUBLIC LAW 98-160, SECTION 107)

INTRODUCTION

In early 1983 the Department of Medicine and Surgery of the Veterans Administration submitted a report to Congress entitled "A Plan for the Delivery of Health Care to Veterans in Puerto Rico and the Virgin Islands". This report included information on the geography, economy, and other characteristics of Puerto Rico and the Virgin Islands, as well as a description of the health care capabilities of the non-VA sector. The report also included extensive information on the VA Health Care Delivery sector, including inpatient hospital care, outpatient care, and nursing home care.

One problem encountered in that study was the fact that only preliminary data based on the 1980 Census was available for veteran population projections. Since publication of that report, the Bureau of the Census has released the final results of the 1980 Decennial Census. During the preparation of this report the statistics released by the Bureau were compared with the estimates which were developed by the VA for use in the study. This comparison revealed no substantial differences between the estimated and actual veteran population numbers, although the actual age distribution was slightly younger than that shown in the preliminary VA data.

1980 VETERAN POPULATION FOR PUERTO RICO

Age	VA estimate	Census figures
17 to 24	4,700	4,600
25 to 44	47,700	48,500
45 to 54	30,200	37,200
55 to 64	34,400	26,600
65+	13,000	9,000
Total	130,000	[1] 125,800

[1] Note: Detail may not add to total shown due to rounding.

Veteran utilization of VA health care facilities in Puerto Rico and the Virgin Islands has not changed substantially since the release of the report either. When the information for the most recent complete fiscal year (1983) is compared with the workload information from fiscal years 1978 thru 1982, there are no significant changes in the trends, although increases in medical discharges and shorter average length of stay have resulted in lower occupancy rates for medical beds.

SAN JUAN VAMC [1]—DISCHARGES FROM MEDICINE, SURGERY, AND PSYCHIATRY

[Fiscal years 1978-83]

Bed section	1978	1979	1980	1981	1982	1983
Medical	4,237	4,157	4,401	4,253	4,349	4,976
Surgical	3,638	3,594	3,447	3,606	3,495	3,447
Psychiatry	1,660	3,032	3,296	3,231	3,090	2,887
Total	9,535	10,783	11,144	11,090	10,934	11,310

[1] Source: Patient Treatment Files (PTF) Report 881.

SAN JUAN VAMC [1]—AVERAGE LENGTH OF STAY FOR MEDICINE, SURGERY, AND PSYCHIATRY

[Fiscal years 1978–83]

Bed section	1978	1979	1980	1981	1982	1983
Medical	20.4	21.1	18.6	19.5	17.4	14.9
Surgical	17.3	16.9	17.0	16.1	16.1	15.7
Psychiatry	49.0	28.8	24.1	26.1	26.3	28.2
Combined	24.2	21.8	19.7	20.3	19.5	18.6

[1] Ibid.

SAN JUAN VAMC[1]—OCCUPANCY RATE FOR MEDICINE, SURGERY, AND PSYCHIATRY

[Fiscal years 1978–83]

Bed section	1978	1979	1980	1981	1982	1983
Medical	95.1	96.5	90.6	91.3	83.3	81.6
Surgical	99.6	96.1	92.8	91.9	89.1	85.7
Psychiatry	92.8	99.7	90.7	96.3	92.8	92.9
Combined	95.5	97.5	91.0	93.2	88.2	84.5

[1]Calculated as follows. (Discharge times average length of stay) divided by (365 days per year times number of days in bed section).

SAN JUAN CONTRACT INPATIENT[1]—DISCHARGES AND PATIENT DAYS FOR MEDICINE, SURGERY AND PSYCHIATRY

[Fiscal years 1978—83]

	1978	1979	1980	1981	1982	1983
Medicine:						
Discharges	1,244	1,206	1,107	801	603	962
Total patient days	33,135	17,753	9,597	10,416	15,806	8,417
Surgery:						
Discharges	397	298	137	232	197	197
Total patient days	4,532	3,932	4,860	5,823	5,056	3,668
Psychiatry:						
Discharges	2,827	2,273	2,144	2,136	1,341	1,803
Total patient days	201,697	175,819	190,736	200,821	166,502	181,402

[1] Source: Summary of Medical Programs.

OUTPATIENT CARE

[Fiscal years 1978–83 Workload]

	1978	1979	1980	1981	1982	1983
San Juan[1]	202,774	196,806	207,015	195,925	192,657	199,856
Mayaguez[2]	56,507	51,322	48,497	47,132	44,841	44,301
Fee basis[3]	91,770	74,130	91,922	77,461	88,791	100,022

[1] Ibid.
[2] Ibid.
[3] Ibid.

RESPONSE TO AUDIT BY INSPECTOR GENERAL

In February 1983 the Veterans Administration's office of Inspector General released a report entitled "Report of Special Audit, Veterans Administration Medical and Regional Office Center, San Juan, Puerto Rico (Report No. 3R2-A05-043, dated February 22, 1983). The VA has taken a number of significant steps bearing on the administration of health care in Puerto Rico and the Virgin Islands as a follow-up to actions recommended in that report. In that publication the Inspector General reported that the $100 million service-connected compensation program adminis-

tered by VAMROC San Juan needs improvement. It was their opinion that past management practices both within the regional office and the medical center contributed to a "statistically abnormal" number of service-connected psychiatric claims being granted in Puerto Rico (4.3 percent of the veteran population vs. 1.1 percent VA-wide), as well as an unusually high proportion of those claims being evaluated as 100 percent disability (55.5 percent vs. 24.3 percent VA-wide).

The IG stated that facility management did not provide the necessary level of control over the quality of either rating actions or psychiatric compensation and pension examinations. While a number of claims were rated as a result of fee basis or contract care summaries, allegations of excessive reliance on fee basis examinations and contract hospital summaries were not substantiated.

The IG concluded that a systematic project to reevaluate ratings would result in significant reductions in rating degree of disability.

The Inspection General made the recommendation that the Chief Benefits Director and Chief Medical Director jointly review existing service-connected psychiatric ratings and develop procedures to assure the future integrity of the program in Puerto Rico. Specifically, they recommended that the following be done:

Insure that only certified or board eligible psychiatrists examine patients;

Develop evidence concerning the veteran's capacity to function independently in the community and labor force; and

Review claims files using designated medical, legal, and occupational rating specialists.

As a result of management initiatives, the Department of Veterans Benefits now requires that, for evaluation purposes, private physician and fee basis physician statements must be verified by a VA examination to be conducted by a board certified or board eligible psychiatrist. In addition, the adjudication officer at San Juan has been directed to initiate a period dialogue with the examining psychiatrist in the C&P examining unit. The intent of the dialogue is to improve the quality of the examinations upon which disability ratings are based.

With regard to those veterans already on the rolls, the VA has initiated a review of all unprotected 100 percent ratings for neuropsychiatric conditions not scheduled for re-examination. Unprotected ratings are ratings which have not been in continuous force for 20 or more years and are consequently not subject to protect from reduction under 38 U.S.C. 110. There are approximately 3,900 such cases. They have been scheduled for re-examination over a four year period.

The VA is also in the process of initiating procedures which will require that all neuropsychiatric examinations on initial, reopened claims, and claims for increase are reviewed in Central Office prior to being accepted for rating purposes and that rating jurisdiction in initial, reopened and increased claims are assigned to a station other than San Juan.

These four major changes will result in the establishment of control of the Compensation and Pension neuropsychiatric caseload at San Juan. It will also serve to protect the rights of the veterans involved, and insure that they receive the benefits to which they are entitled by law.

PLANNING—PUERTO RICO AND THE VIRGIN ISLANDS

VA planning to meet health care needs of veterans in any area or region cannot be undertaken in isolation from the spectrum of national needs and priorities. As we advised Congress in our report in early 1983, there are unique aspects to health care planning in Puerto Rico and the Virgin Islands. These include limited alternatives to VA medical care, complex economic problems, a near absence of nursing home beds, and low quality of non-VA psychiatric care. Our planning has and will take these and other specific factors into account.

Yet that planning must take place in a framework—a framework set by a budget process and by national responsibilities. That planning process must be deliberate and must take account of the importance of setting pressing needs in one locale in a broad context. Responsible long-term planning for Puerto Rico and the Virgin Islands must allow for consideration of the range of major issues facing VA and the Congress. In responding to the needs of Puerto Rico and the Virgin Islands, we must frame our planning to balance those needs with the burgeoning demands on VA health care facilities experienced in Florida and other Sunbelt areas. We must also consider the anticipated impact of the aging veteran phenomenon, and the need to maintain, and where necessary to upgrade, our health care facilities to assure that the VA health care system remains capable of providing quality health care throughout the Nation.

The VA has developed a mechanism for such nationally focused planning in its Medical District Initiated Program Planning—MEDIPP.

Over the past year the Department of Medicine and Surgery has more fully implemented that strategic planning process. This is the Department's tool for developing a long term health care delivery plan based on extensive participation of personnel from facilities, districts, and regions. To assure consistency in assessing future needs the VA developed various workload forecasting models and other guidance for use during the planning effort. These methodologies, including the hospital inpatient sizing model, were applied to project future need in Puerto Rico just as they were applied for every other facility in the system. The hospital sizing model is based on the assumption that current utilization is a reasonably accurate measure of demand and can therefore be employed to develop projections of future workloads.

Medical District 3, which includes the San Juan VAMC, submitted their MEDIPP plan in November of 1983. This plan is subject to extensive review by the Veterans Administration Central Office prior to the implementation of any of the planning recommendations. Although many of the needs identified are supported with quantitative justifications, one of the major considerations of the agency is the competing priorities for funds. The need in Puerto Rico must be evaluated in light of the needs determined through MEDIPP for the other hospitals and many health care delivery programs within the VA system.

The results of the Central Office review of Medical District plans will be completed in the Spring of 1984, and these results will be used in formulating VA's budget request for fiscal year 1986. For fiscal year 1985, the President's budget includes $9 million for construction at VAMC San Juan of a 120-bed nursing home care unit and a 10-bed rehabilitation center. A prospectus on this project is set forth in Appendix A.

Congress, in Public Law 98-105, extended for one year the special authority in Puerto Rico and the Virgin Islands to provide contract hospital care and outpatient care to obviate the need for hospital admission to any veteran. Neither VA nor Congress has viewed such authority as an ultimate resolution for the provision of care. Extensions to such authority have been deemed necessary, however.

The challenge to provide an equitable response to the health care needs of veterans in Puerto Rico and the Virgin Islands consistent with the Agency's national responsibilities will be met. To assure that VA can do so, however, will require the help of Congress. We would urge that the Agency be permitted to provide continuity of ongoing care to veterans in Puerto Rico and the Virgin Islands for another three years. This will require an extension of VA's special contracting authority.

APPENDIX A

Construction, Major Projects
VAMC San Juan, Puerto Rico
120-Bed Nursing Home Care Unit and
10-Bed Blind Rehabilitation Center

I. Budget Authority

Total Estimated Cost	Available Thru 1984	1985 Request	1986 or Future
$ 9,000,000	...	$ 9,000,000	...

II. Description of Project

This project proposes to construct a new building to house a 120-bed nursing home care unit (NHCU) and a 10-bed blind rehabilitation center (BRC). The building will be two stories with capability for two additional floors. As designed, the building will abut the hospital with all support and traffic between the new construction and the main hospital using this connection. Some minor renovation on the first and second floors of the existing hospital at this point of connection will be necessary. Because the existing outdoor recreation area for the psychiatric patients will be destroyed by the erection of the new building as part of this project, a new recreation area will be created south of the hospital now occupied by a parking lot. The structure will have complete sprinkler and air conditioning systems installed.

An environmental assessment has been completed. The only adverse impact is a further decrease in the already deficient number of parking spaces.

III. Justification for Project

The number of nursing home care beds for Medical District No. 3 (as reflected in the November 1982 Medical District Initiated Planning Program submission) was set at 1140 beds. Currently there are 660 nursing home care beds in the District. With completion of 120 beds at Medical Centers Bronx, Northport, and San Juan the District will be 120 beds short of its projected bed level. In addition, as stated in a report by the Department of Medicine and Surgery (pursuant to the requirements of the House and Senate Joint Explanatory Statement on Passage of Public Law 97-251), titled A Plan for the Delivery of Health Care to Veterans in Puerto Rico and the Virgin Islands, "the rapid rise in the aging veteran population, along with the proportionately larger number of veterans with service-connected disabilities a higher number of veterans in lower economic status, and limited availability of alternatives for long-term care, the demand for nursing home beds in Puerto Rico is expected to increase significantly." This project will help achieve the goal set forth in Public Law 98-160, that is ". . . for meeting the health care needs of veterans in the Commonwealth of Puerto Rico and in the Virgin Islands who are eligible for health care under Chapter 17 of title 38, United States Code, and, particularly the health care needs of veterans whose disabilities are service connected." The nursing home project will provide care for eligible veterans in a VA owned facility with VA staff and VA supervision.

No current figures are available as to community nursing home care beds. However, the latest data available (1976) indicate there were 13 non-VA nursing homes in Puerto Rico with a bed capacity of 987 beds. Data provided with 1983 Medical District Initiated Program Planning (MEDIPP) submission indicates that as of 1982 the VA contracted 51 community nursing home beds. It is projected for 1990 that 49 beds,will be available in the community on a contract basis.

Currently, all blind rehabilitation for the approximately 600 eligible veterans in Puerto Rico is done at Medical Center West Haven, Connecticut. This distance and the significant cultural shock are an ordeal few veterans wish to undergo, and if they do attend, they regress after a period of time because they lack the refresher courses necessary to keep their skills current.

The primary reason for this project is to provide the number of additional nursing home care beds and blind rehabilitation beds the Medical District plan determined are needed at this Medical Center. Efficiency of operation and improved patient treatment are project goals, but are not the primary reason for this project.

IV. Background

Several alternatives, other than a new structure, were explored by the VA. The San Juan Medical Center has and will continue to operate at a very high bed census. No room was available within the existing hospital to provide 120 nursing home care beds and support and a 10-bed blind rehabilitation center. The purchase of an existing private medical facility four miles from the Medical Center was not feasible because the cost of purchase, needed renovation, and the additional staff required to operate a distant facility would be more expensive than a new structure on the Medical Center's grounds. The Medical Center's grounds, existing buildings, parking, and road system, and the site's physical contours, left only one site capable of handling a 120-bed nursing home care unit in a functional manner with appropriate connections to the main hospital.

APPENDIX A

Construction, Major Projects
VAMC San Juan, Puerto Rico
120-Bed Nursing Home Care Unit and
10-Bed Blind Rehabilitation Center

V. Correction of Code Deficiencies

The nursing home care and blind rehabilitation building will be a totally new structure, designed and constructed to meet all current code requirements.

VI. Schedule

Complete preliminary plans	09/30/83
Complete construction	04/11/88

VII. Project Cost Summary

			Cost
New Construction	59,361 gross square feet @ $106.79		$6,339,476
Alterations			N/A
Subtotal (new construction and alterations)			6,339,476
Other Costs:			
a. Sitework, utilities, demolition and surface parking		$771,000	
Total Other Costs		771,000	771,000
Total Estimated Base Construction Cost			$7,110,476
Construction Contingency	(5 percent)	356,000	
SBA(8a) Allowance		N/A	
Contingency Reserve		356,000	356,000
Technical Services	(7.5 percent)		560,000
Total Estimated Base Cost			$8,026,000
Total Estimated Project Cost			9,000,000
Inflation Allowance			974,000

VIII. Annual Operating, Staff and Equipment Cost

	Project Activation Costs		Present Facility Operating Costs	
Equipment Cost	$690,000			N/A
One time non-recurring cost	210,000			N/A
Recurring costs:				
Additional manpower	FTE: 137	$3,562,000	FTE: 1700	$39,385,000
Other recurring		1,070,000		19,509,000
Total recurring		$4,632,000		$58,894,000

IX. Executive Order 12372 Compliance

The VA notified the State Clearinghouse on June 24, 1983. An acknowledgement was received from the State Clearinghouse on July 5, 1983, with no comment regarding this project.

Mr. EDGAR. Let me ask you another question which grows out of the quality question in the psychiatric area. If we're giving contracts out to the private sector to care for veterans, can we not put more adequate controls on the quality of that care?

Mr. FREEMAN. Mr. Chairman, I want to complete my plan for what I think is going to help the situation in the contract hospital immediately.

The Hato Rey Hospital is the hospital we're most concerned about. We think it's very bad. The Hato Rey Hospital Association is in the process of constructing a new facility. I reconfirmed this morning that in January 1985 the new building will be completed.

Mr. EDGAR. What will be the ratio of patients to staff in that new facility?

Mr. FREEMAN. I cannot guarantee that this will improve. The only thing I can guarantee will improve is the physical plant.

Mr. EDGAR. Can't we demand that in our contracts, that the ratio of staff to patient be a certain level?

Mr. FREEMAN. This is the first year we've had a definitive contract with these facilities and we have added more controls to these contract patients than we had in the past. It is our plan, yes, to try to add more controls.

The only thing I can guarantee with the new facility of the Hato Rey Psychiatric Association is that as a new facility, it will be much better than the conditions in which our patients are being cared for at the present time.

They have assured me that they will be transferring patients to the new facility in February 1985. It is my plan to continue with the psychiatric intervention unit, screening these patients on occasion, bringing them from the contract hospital to our hospital clinic, a full-time psychiatrist to monitor these patients while they are in this contract hospital. I think, by February 1985, we will have patients in better conditions.

During this time we will also be negotiating the new contracts for 1985 and, with these new stipulations and with a full-time person to monitor the program, I think we can make improvements. It's hard to get the hospital to put improvements into a facility when they know in 6, 8, 10 months they're going to be moving to a new location.

However, I think with the full-time person we can improve this situation to some extent.

Now, we have another contract hospital called Fernandez Garcia. There we have 139 patients who have been determined more or less to require psychiatric nursing-home-type care. I think, we can reduce the number of these patients requiring care through the work of full-time psychiatrists.

I would like to move these patients to the nursing home, when it's completed in 1987.

Mr. EDGAR. Let me ask you a question about the first contract hospital you talked about.

Mr. FREEMAN. Yes, sir.

Mr. EDGAR. Are they building that new facility based on their contract that they have with the VA or based on projected needs minus the VA patients?

Mr. FREEMAN. We have told them that we have plans and hope someday to have our own psychiatric wing and that they cannot depend on having VA patients. They have assured us that they feel the community is in need of psychiatric beds to the point that they will continue to survive.

However, at this point they are still saying they need the VA patients for the hospital, because we control the majority of the patients in their facility at this time.

Mr. EDGAR. As chairman of this subcommittee, I would urge you strongly to not only monitor your contract and negotiate it in the best care and quality for the veterans as you can, but make sure that we're not giving a pork barrel to a private institution simply because the VA has other priorities and is not able to move with construction of their own facility at this point.

Because, as I understand the quality of that care, it is not even near the level of quality that you would want if a member of your family had to be institutionalized. The length of stay is much longer than in a normal psychiatric setting. I just think that we have some responsibility to those in our society who are mentally handicapped.

Mr. FREEMAN. Finally, I'm going to propose, when I get back to Puerto Rico, that a task force, chaired by the chief of staff of the hospital be convened to study the Hato Rey Hospital and any avenues, in addition to the full-time psychiatrist, that might improve the care.

Mr. EDGAR. The chairman of the full committee has joined us. I wonder if Mr. Montgomery has any observations or comments to make?

Mr. MONTGOMERY. Just maybe a couple of questions and one comment, Mr. Chairman. I will be brief.

I'd like to commend you for sending part of your staff and the minority staff down to Puerto Rico. As I understand it, there were two staff members from the Senate along with you.

Mr. Freeman, you've got a tough job but they say you can do it.

Mr. FREEMAN. Thank you.

Mr. MONTGOMERY. It's a tough job there in Puerto Rico.

What about the patient care of the veteran that comes in the veterans hospital for acute care compared to what a Puerto Rican would get in the private hospital? How does it compare?

Mr. FREEMAN. Well, that's one of the things that faces us in Puerto Rico. As the Commissioner said, the attitude of the whole island is that if you're a veteran you have to go to the VA hospital. Only 3 weeks ago I had a veteran who had a neurological problem. We sent him to one of the regional hospitals. He laid there 48 hours and was still sent back to the VA hospital once it was discovered he was a veteran.

If a veteran doesn't get treatment at our hospital, many times he goes untreated. That is the feeling of the people in Puerto Rico, that if you're a veteran you go to the VA hospital. The other facilities are unbelievably overcrowded, more crowded than we are.

Mr. MONTGOMERY. My question is which is the best care, the veterans hospital in Puerto Rico, in San Juan, or the private hospitals?

Mr. FREEMAN. There's no doubt the VA hospital in San Juan is the leader in all health care in Puerto Rico. We're looked up to by all facilities. As a result, we're expected to be the leaders and providers of many, many things for the community as well.

Mr. MONTGOMERY. We were in Roosevelt Roads recently in Puerto Rico. They have a fine military hospital there, and under legislation that was partially implemented by this committee we were able to get cooperation between the Veterans' Administration and the military facilities. Are you getting cooperation from the Navy? Tell us, you know.

Mr. FREEMAN. Yes.

Mr. MONTGOMERY. A number of us serve on the Armed Services Committee also.

Mr. FREEMAN. We require very little from the Navy, mainly because it's isolated and away from transportation for our veterans. I think the cooperation is on our side of the fence. We're working very closely with them. We're taking care of a lot of their patients, and we're proud to do that.

But I really haven't asked for anything that I haven't received from the Navy. We're so independent that there's not much that they have that we don't already provide. Of course, being so far from San Juan, where a majority of the veterans are, it's hard for us to ask them to provide outpatient services because it would be difficult getting the patient there to receive the outpatient services.

Mr. MONTGOMERY. How about the beds at Roosevelt Roads?

Mr. FREEMAN. Yes, Roosevelt Roads.

Mr. MONTGOMERY. Do they have many vacant beds at the military hospital?

Mr. FREEMAN. Yes, sir, I think they're only operating at about 60 percent capacity. I think the hospital could run as much as 120 beds during wartime but they're running about 50 to 60 beds now.

Mr. MONTGOMERY. Couldn't you use some of those beds, ask them if they're not being used? Could you use them if you're full in your hospital?

Mr. FREEMAN. It's a very difficult question to answer. Yes, you could, provided we could get the veterans to participate. We would have to transfer them there and then transfer them back.

Dr. CUSTIS. If I may add to that answer, Mr. Montgomery, we, approximately 2 years ago, specified to the Navy certain things that we would like for them to do for us in Puerto Rico. The answer that we received, and I am satisfied that it is an accurate answer, was that they are minimally staffed in Puerto Rico.

If the VA should ask for dedicated beds it's quite apparent that we would have to provide the staff to care for the patients in those beds. This, too, was suggested in the course of our conversation with the Navy and it wasn't affirmatively responded to.

Mr. MONTGOMERY. Thank you, Mr. Chairman.

Mr. EDGAR. Thank you. I'd like to yield now to John Paul Hammerschmidt.

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman. Dr. Custis, we appreciate your being here and we appreciate your testimony.

Let me address this question to you and you may want Mr. Freeman to answer it. The length of stay at the Hato Rey contract hospital is said to be about three times as long as the length of stay at the San Juan medical center. I heard Balta testify this morning it was four times as long. How do you account for that?

Dr. CUSTIS. Primarily because there's a different case mix in the two institutions. The San Juan medical center is primarily an acute medical, surgical, and psychiatric hospital. There are very few long-term beds of any variety. Alternatively, the Hato Rey Hospital is a long-term psychiatric facility and we have some genuine concerns that there is a length of stay there that is unnecessary. That's why Mr. Freeman's use of a psychiatrist dedicated to supervision of our patients in that hospital, holds a lot of promise.

Mr. Freeman told me yesterday that not too long ago a patient was discovered in the Hato Rey Hospital that had been there 11 years.

Mr. HAMMERSCHMIDT. Well, I know we've discussed Hato Rey extensively here this morning with the chairman, but there are some who feel that treatment at the Hato Rey Hospital is so substandard that veterans should not even be placed in that facility. And I know you've been quoted, Dr. Custis, as being very critical of Hato Rey and I wonder if you have any further comment about it, about the terrible situation down there, as we view it?

Dr. CUSTIS. Yes, I do. As a matter of fact, when I visited Hato Rey I said it reminded me of a leper colony that I had visited in Vietnam. It's inexcusably poor.

Aside from trying to reduce the population by attrition through more careful screening, by firsthand VA supervision of those patients and discharging those that can be discharged, and by waiting for the completion of the new building at the Hato Rey Hospital, we're very frustrated as to what, additionally, we could do to suddenly do away with the use of that facility.

If there were a way to do so, we would certainly grab it.

Mr. EDGAR. Would the gentleman yield?

Mr. HAMMERSCHMIDT. Yes; let me ask one more question, then I'll yield.

How many patients are service connected in Hato Rey?

Dr. CUSTIS. Do you have that percentage?

Mr. FREEMAN. We estimate that it's 70-percent service connected versus 30-percent nonservice connected. It can fluctuate, but a majority of the patients are service connected.

Mr. HAMMERSCHMIDT. It'll average around 70 percent?

Mr. FREEMAN. I would guess that; yes, sir.

Mr. HAMMERSCHMIDT. I yield to the chairman.

Mr. EDGAR. I was just wondering. Has there been any speculation at all of the VA actually purchasing the hospital that's being constructed? I don't know the quality, shape, size, but I know when the VA goes to build something they build it for withstanding nuclear attacks or whatever, and it costs a lot of money.

Would there be a possibility of looking at that hospital and taking it over and having the VA staff, VA people, VA standards provided in that facility? Of course, you'd need an increase in your manpower ceilings. You'd need all of those auxillary things. But has there been any discussion?

Dr. CUSTIS. Not only has there been no consideration of that, but I haven't been aware that that's a possibility.

Mr. FREEMAN. This was brought to my attention by one of the committee members, Mr. McDonell. Someone said when they visited the Hato Rey Hospital that he'll be happy to sell the facility to the VA, and that's the only knowledge I have of it.

Dr. CUSTIS. No; he's talking about the present facility.

Mr. FREEMAN. No; the new facility is what I understood, that they would be willing to negotiate with the VA to buy this. No one has contacted me from the psychiatric association and I haven't talked with them in any way about any type of purchase of a building.

Mr. HAMMERSCHMIDT. If I may reclaim my time.

Mr. EDGAR. I yield back to Mr. Hammerschmidt.

Mr. HAMMERSCHIMDT. How did that hospital get accredited?

Mr. FREEMAN. Sir, I don't know. They tell me it's accredited. They have not produced proof to me that the Joint Commission has given them accreditation. But, yes; they do assure me, and my staff, and all the visitors there that it is a Joint Commission accredited hospital.

It's certainly not the same standards we have to follow at the VA, I know that.

Mr. HAMMERSCHMIDT. It must have been accredited under different standards.

Dr. CUSTIS. That would be in the category of a miracle.

Mr. EDGAR. Miracles are gratefully accepted, but I don't think there was one in that case.

Mr. HAMMERSCHMIDT. Mr. Freeman, I understand you are doing a good job and you're trying to get things turned around down there, and we appreciate that. You mentioned or it was mentioned here earlier, that as one approach, that you have been placing a number of previously hospitalized mentally disabled veterans in halfway houses or returning them to their homes. That costs about $200,000 a year but you estimate, or I've seen the estimates, that it's saved about $1 million. Is that correct?

Mr. FREEMAN. Yes, sir; we've saved about $1 million in contract hospitalization through our cutback. This is true.

Mr. HAMMERSCHMIDT. So it would obviously be logical to pursue that approach.

Mr. FREEMAN. I'm predicting this year we will save a half a million dollars.

Mr. HAMMERSCHMIDT. Dr. Custis, what do you see as the future of the VA medical program in the Virgin Islands?

Dr. CUSTIS. I did not visit the Virgin Islands. My knowledge of the need down there is based entirely on the report of several years ago of the Caribbean facilities and the MEDIPP district plan.

In both cases the opinion is given that the quantity of veteran entitlement in the Virgin Islands does not justify a clinic. The need for readjustment counseling in the Virgin Islands, however, is something else again, and that's the reason for the satellite facility that's been established there.

Mr. HAMMERSCHMIDT. Dr. Custis, even before your planning process is complete, you already know that Puerto Rico has a patient-

employee ratio of about 1.51. How does that compare with other hospitals which are somewhat similar to Puerto Rico?

Dr. CUSTIS. Could we supply that for the record, sir?

Mr. HAMMERSCHMIDT. Would you please supply it for the record?

[Subsequently, the Veterans' Administration furnished the following information:]

Comparison of VA medical center core staffing ratios, fiscal year 1982

VAMC San Juan	1.51
VAMC St. Louis	1.88
VAMC Houston	1.74
VAMC North Chicago	1.67
VAMC Cleveland	1.88
VAMC Little Rock	1.71

Note.—VA Medical Center, San Juan, is compared above to other large affiliated medical centers that have a large psychiatric bed service. In the future, medical centers will be measured by DRG productivity and staffing standards that are presently being developed and will be 85 percent complete by September 1984.

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman.

Mr. EDGAR. Thank you. Dr. Rowland?

Dr. ROWLAND. To follow up on Mr. Hammerschmidt's question about the length of stay in the Hato Rey facility there, I just want to be sure that I have it straight in my own mind. There are some mental illnesses or psychiatric disorders that require longer hospitalization than other psychiatric disorders. Is that not the case in this particular facility? They do not have patients there that would require longer hospitalization but, in fact, the reason they stay there longer is because of the poor treatment? I just wanted to establish that in my own mind.

Dr. CUSTIS. Yes, sir, I think that's valid.

Dr. ROWLAND. I thank you. Thank you, Mr. Chairman.

Mr. EDGAR. Can I ask a question about that? Do you, in your contract with the facility, have a physician-to-patient ratio?

Dr. CUSTIS. At the contract hospitals?

Mr. EDGAR. That's correct.

Mr. FREEMAN. I had that statistic and read it. It's a very low statistic. I can supply it later. It's very, very low.

Mr. EDGAR. You'll supply that for the record?

Mr. FREEMAN. I sure will. It's in my notes somewhere.

[Subsequently, the Veterans' Administration furnished the following information:]

The physician-to-patient ratio at the contract hospitals in San Juan, Puerto Rico is currently 1 to 50.

Mr. EDGAR. Mr. Mollohan?

Mr. MOLLOHAN. Thank you, Mr. Chairman.

Dr. Custis, in your written statement you talk about the design fund and that's the fund that would be a common pool from which projects, construction projects, could be designed prior to the money for their construction being appropriated. Are you familiar with that?

Dr. CUSTIS. Yes, sir.

Mr. MOLLOHAN. You indicate here that it would save $34 million in fiscal year 1985 alone, in your testimony. I'm very interested in that, of course, because I have a situation, as I think you're aware, in Clarksburg, where we have a hospital, in addition to which has

been authorized by the House—it wasn't by the Senate last year—and it's in the President's budget and we're not going to be doing anything between now and the first of the fiscal year, even assuming we get the appropriation, which I feel confident we will, unless we're able to take advantage of an opportunity like this design fund.

I'm just wondering if that's being implemented this year, I suppose pursuant to the Cranston amendment. Where are we on that?

Dr. CUSTIS. May I defer to Mr. Salmond?

Mr. MOLLOHAN. Sure, certainly.

Mr. SALMOND. The Cranston amendment has been passed by both Houses. I believe the President has not signed the bill yet.

In preparation for possibly going ahead with that, we have asked the Department of Medicine and Surgery to give us a priority order of the 1985 projects so that we could come to the committees and suggest to them which projects we feel we should proceed with. I anticipate that we would be up to the committees before somewhere around June.

Mr. MOLLOHAN. Elaborate on that a little bit. I'm not sure I understand exactly what you're saying.

Mr. SALMOND. What we anticipate in the design fund would be that we would come to the committees on a quarterly basis and say, "OK, we want to go ahead and start the working drawings on these projects in this quarter."

If the Cranston amendment gets approved by the President, the earliest we could do it in 1984 would be the last quarter, and, as I say, we would be up to you and the other committees suggesting which projects we would plan to go ahead with in 1984 and they would be taken from the projects in our fiscal year 1985 budget.

Mr. MOLLOHAN. And assuming the President signs the legislation.

Mr. SALMOND. Yes, sir.

Mr. MOLLOHAN. Then you do anticipate coming up this year for that kind of approval?

Mr. SALMOND. Yes, sir.

Mr. MOLLOHAN. Thank you very much.

Mr. EDGAR. Mr. Richardson?

Mr. RICHARDSON. Thank you, Mr. Chairman.

Dr. Custis, you have received, undoubtedly by now, the letter from the members of the New Mexico congressional delegation regarding the hiring practices of construction companies at the new VA medical center. The concern that we had, those of us in the delegation, was that veterans apparently were not being hired, that there were allegations that there was lack of any kind of assistance to those construction workers that are veterans, to get the jobs that provide substantially for the construction of this new medical unit, and I wondered if you'd had a chance to look at this issue and might have a preliminary response to us for it?

Dr. CUSTIS. Again, may I defer to Mr. Salmond?

Mr. RICHARDSON. Yes.

Mr. SALMOND. There is no provision in the law that says that the contractor has to give any priority to hiring veterans; there is for minorities or veterans who do not come under that category.

Mr. SULLIVAN. Let me just interject something here, though. I think what we can do is speak with the contractor, try to alert him to your concerns, the delegation's concerns, and encourage him to look to employing veterans. But we have no coercive power to be able to compel him to do that, unfortunately.

But I believe I can speak for the Administrator and say that we will, certainly, speak with the contractor regarding that situation.

Mr. RICHARDSON. Well, I think the main concern that many of us had was that the hiring practices of these contractors, they were going out of the State to hire people. They weren't hiring minorities. They weren't hiring veterans. I mean, it just seems to me that—I know this is a local problem, but I would expect, you know, a better response than what you've just given me. It seems to me that efforts should be made, if we're building veterans facilities, and in New Mexico we have a large percentage of construction workers that are veterans and unionized and minorities, and we're making—if we're just exercising no interest, or I'm not saying supervision because you're right, it's not in the law. But it just seems to me that this is something that all of us, it's not just me, it's the entire delegation, would like you to pursue further and hope that you have a better answer than what you just gave me.

Mr. SALMOND. I've been corrected by a member of the general counsel's staff that there is a clause in the contract that the contractor should give preference to Vietnam veterans. But it's not a requirement that he must. And I support Mr. Sullivan. Yes, we will talk with the contractor and see if we can impress him a little bit.

Mr. RICHARDSON. I'd appreciate that and we'll be waiting for your response.

Mr. EDGAR. Thank you. John Paul has one additional question and then I have a shopping list of questions I'd like to ask.

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman.

Dr. Custis, in Puerto Rico if there was a choice of starting that wing of that hospital and building a nursing home, and I'm assuming that, perhaps, that 10 bed blinded rehabilitation unit could be spoken to along with the wing in the hospital, be taken care of in that manner, would you state a preference of what you think would be the most needed, whether it would be the hospital wing, which the $9 million or $10 million could get started on, or the nursing home?

Dr. CUSTIS. I would consider that a very easy question to answer, Mr. Hammerschmidt. The fact that the nursing home is in the budget and not the wing is strictly a matter of dollars. We can do the nursing home for much less money. If it weren't for the competition for dollars in construction we certainly would prefer the clinical additional to the hospital, ahead of the nursing home.

Mr. HAMMERSCHMIDT. Fine. Well, I understand that because you can build a nursing home, I guess, for $9 million or $10 million and the outyears on the wing would be much greater, of course, budgetwise. I appreciate your response.

Dr. CUSTIS. It's the outyear commitment that—where the competition gets rough.

Mr. HAMMERSCHMIDT. Sure. Thank you, sir.

Mr. EDGAR. Dr. Custis, I have before me the list of 10 most wanted hospitals in the report that was submitted to us last year

for fiscal 1984 through 1988. On that list we have Minneapolis, Minn., which has been considered for funding and funded, Houston, Tex., which is in this budget, Allen Park, Mich., which is in this budget, Mountain Home, Tenn., which is in this budget, Pittsburgh is No. 5 and considered for 1986 funding for design and 1987 funding for construction.

The Georgia facility, No. 6, I think, is in this budget. Biloxi, Miss. was funded previously. Gainesville, Fla., is in for 1986 design and 1987 construction. Baltimore, Md., is going to be designed in 1987, is not in this budget for 1985 funding, and the Palm Beach, Fla., one is for 1987 funding.

There are 10 hospitals listed as medical centers, currently judged most in need of construction, replacement, or major modernization.

My first question to you is what criteria do you use to determine which medical centers are placed on this list of the 10 medical centers most in need of construction, replacement, or modernization?

Dr. CUSTIS. I couldn't possibly consider that a rhetorical question, could I, Mr. Chairman?

Mr. EDGAR. No. There will be follow on specific questions. [Laughter.]

Dr. CUSTIS. The matter of prioritizing and specifically listing 10 most needed hospitals, as you well know, has been a subject of controversy for several years. We found it very difficult to satisfy particularly the interested committees on the Senate side, as to the criteria used for those priorities.

At the time all of this was going on, for what it was worth, I tried to disassociate myself from the effort, because I think it is literally impossible to satisfy everybody when you take major projects and try to arrange them in priority order, based on any criteria. I can only say I think that the staff has done the best job that could possibly be done and I would like to submit for the record a definition of those criteria that are used.

[Subsequently, the Veterans' Administration furnished the following information:]

The following are the objective criteria used to determine those projects which are added to the last of Ten:

A CATEGORY DESCRIPTION

As VA facilities get older, they develop critical space and functional deficiencies, in terms of the delivery of modern health care, that require a multiple corrective approach involving either total replacement or major modernization. Such projects involve numerous categories of correction and result from the determination that a comprehensive approach is more efficient and cost effective than a recurring multiple project approach. Replacement/Modernization projects result from compound deficiencies in the areas of patent safety/environment, patient care/support and physical plant obsolescence.

B. PRIORITIZATION CRITERIA

1. "Primary factors"

Patient safety

a. Correction of fire and safety deficiencies as recommended by Fire Safety Evaluation System (FSES).

b. Seismic corrections.

Projected need based on demographics

a. Workloads (current and projected to 1995 for both acute and extended care).

b. Outpatient visits (current and projected to 1995).
c. Deficiencies calculated by VA/GAO Bed Sizing Model and/or Outpatient Project Model.

Existing space and functional deficiencies in patient and clinical areas (using space and functional deficiciency identification (SFDI) comparisons between existing space and approved agency space planning criteria (H-08-9)

a. Nursing units (including compliance with VA patient privacy standards and American National Standard Institute (ANSI) Handicap Barrier Standards).
b. Clinical Support services.

Medical delivery role of VAMC

a. *Type of VAMC* (primary, secondary, tertiary). A higher priority is usually indicated for the tertiary care facility because of the more complex and sophisticated services provided by such a facility. The overall impact on patient care is usually more significant than in a primary or secondary care facility.
b. *Affiliation(s).* The strength of the affiliation(s) to the medical school usually calls for a more symbiotic relationship between the VAMC and the medical school, thus making construction funding at a highly affiliated VAMC more critical than at a non-affiliated for less intensely affiliated VAMC.

2. "Secondary factors"

Technical deficiencies

a. Age and structural condition of building(s) shell.
b. Condition of site utilities, electrical and mechanical systems.
c. Energy conservation.

Nonclinical support service deficiencies

a. Warehouse
b. Laundry
c. Boiler Plant

C. PRIORITIZATION METHODOLOGY

The prioritization methodology used to rank the Replacement/Modernization projects on the fiscal year 1985 project list was limited to a comparative needs assessment on their own merits and prioritized relative to one another. Prioritization of the Replacement/Modernization projects was based on a relative assessment of each project in terms of such major planning components as the relative impact of the medical center within the VA health care system, patient safety and code compliance, projected bed and outpatient service needs, patient environment and clinical service requirements, physical plant and support deficiencies and finally, the professional evaluations of program officials and Regional and District Directors.

"Primary Factors" include those considerations determined to be the most important in terms of the delivery of quality medical (patient) care within the VA health care system. There "Primary Factors" encompass patient safety (e.g., fire/safety deficiencies); demonstrated need based on demographic analyses; space and functional deficiencies in patient and clinical areas; compliance with patient privacy and handicap access standards; and the medical delivery role of the medical center in the VA system (type of VAMC and degree of affiliation). Thus, a project which, in a relative sense, exhibits a more serious degree of fire and safety deficiencies than another gets a higher rating in that category; the project with greater space and functional deficiencies is given a higher rating, and so forth. Likewise, in considering demographics, the VAMC that is projecting the greater increase in patient days or outpatient visits, but is saddled with the least adequate facilities to support this increase, becomes the higher priority project.

Finally, greater emphasis is placed on the more active, highly affiliated and specialized Medical Centers because of the more sophisticated level of medical, surgical and psychiatric care provided.

"Secondary Factors", while also important to the operational functioning of a modern health care facility, include deficiencies which impact indirectly on patient care. "Secondary Factors" encompass the age and condition of the building(s) shell and site utilities, mechanical and utility systems; energy conservations; and the condition of non-patient support functions such as laundry and warehouse. Within these factors, greater emphasis is given to corrections of the most serious identified deficiencies.

The evaluation of a Replacement/Modernization project against the primary and secondary factors results in its relative priority. More emphasis is given to the "Pri-

mary Factors" as these impact directly on patient care. These evaluations also encompass input from program official(s) and the Regional and District Directors.

As projects are removed from the List of Ten, after approval of Construction funding, other projects from the Replacement/Modernization category are added to the list.

Dr. CUSTIS. In the last analysis, though, after you get through using the criteria, there remains a large element of subjective judgment. Who is to say, in the last analysis, whether hospital A, which is badly in need of replacement or repair for A, B, and C reasons, has a higher priority than hospital B, who may have different reasons, but equally compelling. It's an almost untenable spot that we have been put in, I submit.

I also feel free to say that the Administrator feels that it is possible and is needed to have a list of 10 but he thinks it is inappropriate to try and prioritize among those 10, which should come first, second, and third.

I know I haven't answered your question, Mr. Chairman. You've only provoked my frustration.

Mr. EDGAR. There is for funding in the President's budget, which he's just set forward, a number of $93,300,000 for major construction, outpatient, and clinical addition, alteration to a facility in New York, which needs to consolidate a satellite outpatient clinic currently located at 252 7th Street in the Medical Center, New York. The project is based on space program of approximately 190,000 net square feet involving both construction and new addition and adjacent.

As I look on page 2987 of the document "Medical Construction and Leasing Authorizations, Congressional Submission Fiscal Year 1985, Volume Six" I'm impressed with the detailed analysis of that New York project, and I'd like to ask your specific reasoning for including that project in the budget over other projects that are presently on the list of 10, and what is it about the New York project that brings it to the surface and calls upon this administration to want to fund it as aggressively over other projects that have been authorized?

Dr. CUSTIS. Well, I think I am not being inconsistent when I say I find difficulty in answering that question for the reasons I gave in answering the previous question. I can only say that the project in Manhattan has been in the planning stage for as long a period of time as any of the other projects. The Manhattan hospital is very crowded. New programs have been implemented in the Manhattan hospital over a period of years that has further strained the facility.

Mr. EDGAR. Dr. Custis, isn't it true that we have to authorize the New York hospital, that that is not an authorized hospital at this point?

Doesn't that have to be approved by a committee resolution?

Dr. CUSTIS. Yes, sir. In the context of considering the 1985 budget, you mean? Everything in the 1985 budget is in the same category, as I understand your question.

Mr. EDGAR. No, I don't think so, because the other projects that I see funded, most of the projects on your shopping list, have already received committee authorization.

Dr. CUSTIS. Oh, I see. Yes.

Mr. EDGAR. And the Congressmen from New York will have to come and make their case before this committee and you, as the VA, will have to make your case before us and we'll have to pass a resolution indicating our approval of that particular facility. And I guess I'm frustrated with you in terms of being able to define what is a priority. We have the Baltimore facility on the list for some time, the need for a replacement hospital had been identified.

There was also a planned hospital in Camden. I worked with other people to delete the Camden hospital because there were lists of priorities. But we were able to put back in the Baltimore facility as a priority hospital for replacement, and when Baltimore and Camden were deleted many years ago, there was a great hue and cry and Baltimore was included.

Camden was not because there was an excess of beds in the Philadelphia metropolitan area, generally, in the private sector. And we felt that if there were priorities to be made, maybe renovating the existing Philadelphia facility and providing outpatient clinic and a nursing home facility would be a better way to go than spending $300 or $400 million on a new facility.

That project has, in fact, been authorized. The Philadelphia project is one that Congress is interested in, and I wonder if you could indicate for me why we would jump in with a hospital in New York, as important as that facility is, it hasn't been authorized by committee resolution, is necessary for replacement, and if we had a blank check and all the funds in the world we'd go ahead and do as many of these as we could.

But we bump up against the design plans time requirements and jeopardize the possibility of some land that's been donated by the city of Philadelphia, in one case, in prioritizing that other facility. I want to know from you what makes the New York facility more important and more valuable for urgent funding in 1985 fiscal year than the Philadelphia facility, which needs urgent funding in the 1985 fiscal year to protect some land that's been donated by the city?

Dr. CUSTIS. May I interpret that as you're asking my opinion?

Mr. EDGAR. I'm asking your opinion, your personal opinion.

Dr. CUSTIS. I think there is nothing about the New York project that is more important than the Philadelphia project. As you undoubtedly know also, the Administrator's budget, 1985 budget, contained the Philadelphia project.

Mr. EDGAR. I celebrated that with the Administrator a week or so ago and am pleased that on two occasions the Administrator of the VA had moved aggressively to include the $18 million funding for the Philadelphia facility. I'm not casting blame on the VA because I understand your process of working with the Office of Management and Budget.

But I think the Office of Management and Budget, the White House, the administration, needs to get its priorities clear in terms of what facilities need to be replaced. We all understand the limitation on funding. But I find it offensive not simply because it's in the metropolitan area around the city of Philadelphia, but that we ought to figure out a way to the best extent possible of making some decisions based on merit, and the fact that the Camden facility was deleted saved the VA a lot of money, and I think saved the

country a lot of money in the long term in maintaining a large, new facility in the Philadelphia metropolitan area.

But under anybody's criteria, the number of veterans, the number of patients, the number of nursing home needs, the number of outpatient needs are catastrophically high in that area and I just think we need a better reason as to why we can find $93 million to do almost the same thing in New York City but not find those funds to do one that has already been identified as having a major need.

I think we'll hear from our Baltimore colleagues as to why Baltimore gets picked on as a facility. What makes it less important than any of these others on the shopping list? Why does it continually get bumped from the list? Is it a need or isn't it a need? You identified it as a need last year. You located it as a need to replace that hospital. We want to get on with it. But now it's bumped out again.

Let me ask a couple other questions.

Dr. Custis, you are proposing to offset your request for major construction projects, $739,594,000, with $120 million from your working reserve fund. What is in the balance in that working reserve fund?

Dr. CUSTIS. At this time $16 million, approximately.

Mr. EDGAR. In addition to offsetting the major construction appropriation and funding reprogramings by Congress, what other uses have been made of the working reserve fund?

Dr. CUSTIS. None.

Mr. EDGAR. Dr. Custis, in S. 1388, now awaiting the President's signature, that bill will authorize use of up to $25 million from the working reserve fund for working drawings on projects before they are approved or funded by the Congress. What projects in the 1985 request will be affected by this legislation?

Mr. SALMOND. I would judge that we could probably handle all of the projects in the 1985 budget with that $25 million except for the replacement and modernization category.

Mr. EDGAR. Would you repeat that again?

Mr. SALMOND. We can probably take care of all of the projects that are presented to you in the 1985 budget except those that are in the replacement and modernization category.

Mr. EDGAR. And they will be funded out of that?

Mr. SALMOND. Yes, sir.

Mr. EDGAR. OK. The drawings for those others will be funded how?

Mr. SALMOND. They are split funded. They are funded in the fiscal year 1985 appropriation.

Mr. EDGAR. Dr. Custis, I understand that you have recently completed a prototype nursing home design. This effort will cost about $1.1 million but should save about $380,000 on each nursing home construction project. How soon do you expect to incorporate this prototype into your design process?

Dr. CUSTIS. Mr. Salmond?

Mr. SALMOND. We're hoping that we can have that ready for the fiscal year 1986 nursing home projects.

Mr. EDGAR. Does that mean there are no nursing home projects in 1985 which will be——

Mr. SALMOND. Some of these projects are based on portions of that prototype study, but not totally.

Mr. EDGAR. Do you plan to share that prototype with states in general who are building State veterans facilities in conjunction with the Federal-State partnership we have?

Mr. SALMOND. If they wish to use it, sir, obviously. But we're committing ours to a computer system and only if their computer system, or the architect they hire, uses the same hardware and software, would it be available to them.

Mr. EDGAR. Are you making that information known to the appropriate agencies State by State?

Mr. SALMOND. We will when we have it completed.

Mr. EDGAR. Dr. Custis, the Alexandria, La., nursing home is one of the five projects whose final design work was to be completed using VA staff. During fiscal 1984, even though the project is part of the fiscal 1985 request, I note this project should be completed in October 1986, while other nursing home projects in the budget have completion dates of a year or more later. Is the early completion due entirely because you have been able to prepare the working drawings while Congress has been considering the 1985 budget?

Do you anticipate similar efficiencies for the other four projects?

Mr. SALMOND. It is exactly as you say. It's because we were able to start the working drawings practically a year sooner than we did the other projects which are funded in the fiscal year 1985 budget. If the President signs the compensation bill, we can proceed with the working drawings of the other nursing home projects.

Mr. EDGAR. Last year this committee went across the country to the six medical regions and we saw new hospitals and old hospitals and looked at the problem of aging veterans, women veterans, atomic veterans, Vietnam veterans, and looked at all of the variety of facilities that the VA offers. Dr. Custis, are you presently satisfied that the 5-, 10-, 15-year plans for the replacement, rehabilitation, reconstruction of the basic facilities under your jurisdiction will be adequate to meet the needs of quality and quantity health care on into the future?

Dr. CUSTIS. No, sir. The more specific answer to that question, Mr. Chairman, can better be addressed in the context of the aging plan that is a needs assessment with those outyears under consideration.

The time is growing short particularly for extended care facilities to be on line in time to be ahead of that curve, the impact of the aging veteran. The Administrator intends to give us some guidance once the aging plan is smoothed and in his hands, and he doesn't intend, indeed, to make use of that information in the 1985 construction budget.

Mr. EDGAR. Well, would you be——

Dr. CUSTIS. I'm sorry, did I say 1985? 1986 construction budget.

Mr. EDGAR. 1986.

As we looked at the different facilities that the VA has, I was personally struck by the fact that we have an awful lot of aging facilities that are going to become due and granted the VA budget for construction and modernization has been increased, there are a lot of needs that we're meeting, I'm real nervous about whether or

not the increase in aging veterans will meet the requirements and the movement of those veterans, particularly to parts of the country, will be met by new facilities and whether or not the old facilities that remain will be completely and adequately upgraded and updated, and I'll have probably more to say about that later.

Let me ask you an unrelated question. Would you personally support, not as an administration official but just your personal opinion, inclusion in the 1985 budget of some funding for home health care to alleviate some of the burden of hospitalization?

Dr. CUSTIS. The Department and the Administrator's budget both had such a provision, and my answer would be undoubtedly yes.

Mr. EDGAR. What would be the amount of money, minimum, to be able to initiate that program?

Dr. CUSTIS. There is in the 1985 budget resources to implement six additional teams. I think that if all of our urban-based hospitals had the ability in the next year or two to provide hospital-based home care, it would take an additional 24 sites.

The record resources required for a single team is around $300,000.

Mr. EDGAR. That would be very helpful, just for my colleagues. We did pass authorizing legislation. That has been something that the VA and your staff has been interested in doing. I think it is an innovative trend for health care, and it would, in fact, alleviate some of the cost of some of the facilities being constructed in certain areas if we could have a better marriage between home health services and the VA, and I'm going to make some attempt to include funding for that proposal in the congressional budget submission. I don't know how successful I'll be. But I wanted to raise that for the record.

Dr. CUSTIS. As you well know, Mr. Chairman, the concept of hospital-based home care is very popular now in the private sector, and both the hospital-based home care and the adult day care centers are being offered now in the vertical integration that's going on in community hospitals.

Mr. EDGAR. I think that there are a number of those kinds of innovative ways that we can decrease the pressure by looking at preventive care, looking at respite care, looking at home health care, looking at day care opportunities, to alleviate some of the pressure of aging veterans on the system, and I really look forward to working with you on figuring out how we do that.

It's, I think, very instructive to look at the real dollars that have been spent in VA health care from 1970 to the present, versus the actual dollars that have been expended, seeing some of those statistics. I've been real impressed with the problem we face.

I also was impressed with your testimony. We talked about readjustment counseling centers recently and some of the other problems of the VA in terms of limitation of staffing requirements and what that does to some of the abilities within the VA to provide good quality health care.

How much money for adult day care program is in the budget?

Dr. CUSTIS. It was lost in the budget cycle.

Mr. EDGAR. How much money would be needed in order to provide that service?

Dr. CUSTIS. The estimated resources needed to take advantage of that provision includes some 110 FTEE and $8 million in operating costs for 15 programs.

Mr. EDGAR. Thank you very much.

Finally, last week I received a letter from Mr. Walters dated February 14, 1984, concerning the VA's construction plans for the Philadelphia VA medical center. Without objection, I'm making this letter a part of the hearing record today.

[The information appears on p. 61.]

Mr. EDGAR. Dr. Custis, we talked earlier about the slipping of the $18 million and what that might mean, and some of us are working to restore those funds. Do you know what the latest estimate for the cost of construction of the VA hospital in Philadelphia is in terms of the renovation of the acute care facility and the nursing home and outpatient clinic that will be constructed?

Dr. CUSTIS. I believe it's $120 million. Mr. Salmond is looking it up right now.

Mr. SALMOND. The total cost is $139.5 million which includes the $18.3 million for design.

Mr. EDGAR. We had a figure in our authorization of $184 million and we are looking at the possibility of seeing the lower figures. But if it slips my guess is those costs might, in fact, increase.

Mr. SALMOND. I have it listed as $139 million.

Mr. EDGAR. $139 million.

We may do something in the reauthorization on that specific level, but we appreciate the work that the VA has done to see that as a priority hospital and it will take some work to convince my colleagues that that is a priority, given the other pressures that are on the budget. But I think the fact that we see slipping in here and there other projects that are important but have not gone through the same process, I think we have some ammunition and some leverage to see if we can't restore those funds.

I'd like to yield to my colleague, Mrs. Johnson, now, for additional questions.

Mrs. JOHNSON. Thank you very much, Mr. Chairman.

I want to ask first, I notice that in your 5-year plan you do show a recognition of the needs of Newington Veterans Hospital in Connecticut and have provided for some physical additions, patient privacy changes, support system, and heating and ventilation changes.

However, I wonder if, in your examination of problems in that area, you are aware of the difficulties we are facing in providing mental health care for veterans in that area. The facilities are very crowded and the wards are split. We are seeing new pressure in that area. If you could get back to me on this—I would like a comment at some other time on your evaluation of that aspect of Newington's hospital.

Dr. CUSTIS. I understand.

[Subsequently, the Veterans' Administration furnished the following information:]

The 1983 MEDIPP plan for 1990 which is currently under review includes VA Medical Center, Newington Connecticut. There is a proposed increase of psychiatric beds over their present allocation. As you know the needs of Newington must be considered along with all other nationwide requirements.

Mrs. JOHNSON. It does represent, in a sense, a fairly new pressure.

Second, I can tell to some extent from this budget, but not in detail, the extent to which your construction plans over the next 5 years have been affected by your consciousness of the needs of women veterans. If you could provide the committee with some rather more detailed evaluation of the impact of women veterans' needs on your construction plans for the next 5 years, I'd appreciate it.

Dr. CUSTIS. Yes.

[Subsequently, the Veterans' Administration furnished the following information:]

All VA construction projects, including new hospitals, nuring homes and domiciliaries, are designed and constructed to accommodate the privacy needs of women veterans. The Agency's Chief Medical Director directed each medical center to survey older existing facilities to identify any physical barriers which may limit access of women patients. All medical centers were instructed to begin necessary renovations or new construction with available maintenance and repair funds or, for larger projects, to include plans for privacy improvements in their Five-Year Facility Plans. This survey is complete and projects are included in the medical center Five-Year Facility Plan or are underway.

Mrs. JOHNSON. I think it's important for us to track your thinking in that regard. Given all the pressures that you face and needs that are there to fulfill, that is a need that in the past has tended to sometimes get lost.

There are a couple of other questions that I want to ask. Just to follow up on Chairman Edgar's question about home health care, have you investigated contracting with existing community agencies to provide home nursing visits, health aide visits, other kinds of support services that would allow, that would prevent, nursing home care?

Dr. CUSTIS. Yes, we have, Mrs. Johnson, and we have had some in certain areas, prototype use of that. Again, I can address that question much more intelligently after the plan for the aging has been acted upon by the Administrator and you receive it as a needs assessment.

Mrs. JOHNSON. OK.

Dr. CUSTIS. I can only repeat what has been covered in past testimony, that in our plans for taking care of that impact that we have explored all manner of options for noninstitutionalized care, both in-house and under contract. We would like very much to attract the attention of all interested parties to have the opportunity to build at the community level cooperative structures that bring together the private sector, volunteers and Federal programs, under one umbrella.

Mrs. JOHNSON. Thank you. I'm very glad to hear you say that because I think those community services not only deserve to be supported but provide an opportunity for connection with communities that is very hard to create through regional hospitals, and I would hope that you will—I will look forward to examining that aspect of the plan as it comes down.

Two very brief questions. First of all, you've allocated $25 million for asbestos abatement projects. What percentage of the asbestos problem will that $25 million address?

Dr. CUSTIS. Mr. Salmond?

Mr. SALMOND. The $25 million is only to be used for the projects that we've requested funding for in the fiscal year 1985 budget.

Mr. EDGAR. I think the question is what is the total amount needed to solve your asbestos problem?

Mr. SALMOND. The VA doesn't have a figure for that, Mr. Chairman, I'm sorry to say. But it's hundreds of millions of dollars, I would judge.

Dr. CUSTIS. Isn't the more accurate answer, Bill, that there's no way of knowing that figure?

Mr. SALMOND. Yes; you're right.

Mrs. JOHNSON. Well, was every one of your hospitals built with asbestos?

Dr. CUSTIS. Prior to the 1950's, yes.

Mrs. JOHNSON. And are the projects that have been chosen for this $25 million, those projects are ones whose air quality reveals the disintegration of asbestos? Therefore, is there the exposure of staff and patients to asbestos-polluted air?

Mr. SALMOND. I don't understand your question.

Mrs. JOHNSON. Well, it's been my experience in dealing with this problem in school systems that when the material gets to certain points of age and disintegration it tends to give off asbestos into the air, so that some situations are more serious than others. In some situations there actually is asbestos in the air and being breathed by whomever works in the building.

In other situations you know the asbestos was used in construction but it doesn't seem to be a free agent. Now, I may be wrong in that. That was my experience in public school problems in Connecticut.

Are you allocating the $25 million to those buildings in which asbestos has become a health hazard?

Mr. SALMOND. The $25 million is for work only in areas where construction will be accomplished for fiscal year 1985 projects.

Mrs. JOHNSON. I do understand that. What I'm trying to determine is is the $25 million simply wherever you're going to be doing construction you put in some extra money to take out asbestos and put something else in?

Mr. SALMOND. Exactly.

Mrs. JOHNSON. Is that what it is?

Mr. SALMOND. Yes.

Mrs. JOHNSON. So, you have not identified asbestos hazards in hospitals in terms of what is happening to the air quality in those hospitals, and you are not specifically addressing those situations with this $25 million?

Mr. SALMOND. That is correct. That's an on-going program within the Department of Medicine and Surgery and they do that with their operating money. They do monitor hospitals where asbestos is known to be, and they attempt to handle it and take care of it with other funds.

Dr. CUSTIS. Mr. McCracken, who is behind us, is from the office in which this work is going on. He might be able to give you an additional detail.

Mrs. JOHNSON. Thank you. I'd appreciate that because I think we know that the long-term consequences of this are so serious that——

Mr. EDGAR. Just turn the switch on over there and identify yourself for the record, please.

Mr. MCCRACKEN. Mr. McCracken. I'm with the Department of Medicine and Surgery.

What Mr. Salmond is saying is the $25 million really identifies the removal of asbestos related to the construction projects in the 1985 appropriation. This is just a small part of the on-going program of identification of asbestos in our medical centers. We use minor construction projects, minor miscellaneous, nonrecurring M&R. We examine all of the alternatives of encapsulating it or removing it or posting notices. We are very aware of the potential hazards. We are hiring industrial hygienists to survey all our facilities. There are circulars issued notifying them of this requirement and we are continuing to discover and correct asbestos in all of our facilities.

Mrs. JOHNSON. But you are able to handle the costs of correcting the problems as you discover them within your normal operating budgets?

Mr. MCCRACKEN. No, not entirely. We set a priority and we do remedial efforts to curtail the free floating of particles and we are addressing it—it's a long-term solution. We would, as Mr. Salmond said, probably spend millions of dollars, or as Dr. Custis says, we have no idea until we continue to have these baseline surveys made by industrial hygienists to discover and recommend.

We may see material on the walls that appears to be asbestos, but until it's removed and tested we are not absolutely sure that that material, in fact, is asbestos. Or, in a sense, pipe covering and other areas behind walls. As we remove a wall we may discover asbestos. It's an on-going program that we would virtually spend millions of dollars if we were to say there was asbestos behind a wall, that we would go to remove it. Then we'd have to remove the wall and put the wall back.

We would have no need to do that. But at some point in the future when we're making other alterations we may, in fact, have to make additional modifications to contain asbestos.

Mrs. JOHNSON. All right. And then just onto the $5 million for energy conservation projects. How much do you expect these conservation projects to save you in energy costs?

Mr. SALMOND. Generally speaking, the payback is in about 10 years.

Mrs. JOHNSON. What is your total list of energy conservation projects that you see as worth doing in the system?

Mr. SALMOND. Well, again, the $5 million is only—it's handled the same way as the asbestos is. It's only for the projects that are in the 1985 budget.

Mrs. JOHNSON. OK. Have you no separate program that looks at energy usage throughout the system?

Mr. SALMOND. Oh, yes.

Mrs. JOHNSON. I want to get some picture of what is your evaluation planning system for issues such as energy usage and conservation. Are any of your construction funds allocated specifically to reduce energy costs in a hospital in order to better release funds for other use in the future?

Mr. McCRACKEN. This is Mr. McCracken. We have, again, a parallel program within the Department of Medicine and Surgery, in our engineering service, and we have an extensive energy conservation program. I would be very pleased to furnish you our figures and our results of the last 2 or 3 years. We show a significant payback on our investment. We are very much on target of our goals in the 5-year and 10-year projections. I think you'll be very pleased once I provide you with the figures in this particular area of energy conservation. It is on-going in each of our medical centers.

We evaluate each project for the cost benefit, the payback, and I think we have a very satisfactory record that we'd be glad to furnish some figures on, Mrs. Johnson.

Mrs. JOHNSON. Thank you. I would appreciate those figures.

[Subsequently, the Veterans' Administration furnished the following information:]

Attached is the VA Energy Conservation Program white paper, dated February 6, 1984, and the projects information.

WHITE PAPER—VA ENERGY CONSERVATION PROGRAM

1. The VA Energy Conservation Program is achieving its goals of saving money and energy without sacrificing the quality of patient care.

2. The $98 million cost of the program for the past seven years, has already provided a savings of $197 million. Although the construction of additional, modern buildings has increased the total square feet by 12.8 percent and the addition of 91,212 tons of air conditioning, for improved patient care, has increased the total air conditioning load by 59.7 percent, the VA used less energy in fiscal year 1983 than it did in fiscal year 1975.

3. The success of the program is due in part to early recognition that the rapidly increasing cost of energy was taking a much bigger portion of the funds allocated for patient care. This led to the development of a program with goals to save money, by conserving energy, without reducing the quality of patient care.

4. By 1977, when the President issued Executive Order 12003 requiring 20 percent energy reductions in existing buildings and 45 percent reductions in new buildings by the end of fiscal year 1985, the VA already had a 5 Year Plan in operation. This was subsequently expanded to a 10 Year Agency Plan.

5. Although the total program is large and detailed, the major components of the program are based on specific goals for each facility; a detailed data bank to monitor each facility's consumption; continuous review of modern technology; training of field station engineers; and VA Central Office Review & Selection of Retrofit projects. The main criteria for retrofit project selection priority has been, and remains, the maximum dollar savings per dollar expended of available funds.

6. Results—end of fiscal year 1983:

22 facilities have exceeded fiscal year 1985 established goals.
66 facilities are now above the 90 percent achievement level.
Current rate of savings—9.9 trillion BTU/yr.
Current rate of cost avoidance—$48.7 million/year.
Cumulative cost thru fiscal year 1983—$98 million.
Cumulative savings thru fiscal year 1983—$197 million.

VA ENERGY MANAGEMENT PROGRAM—NRM PROJECT COSTS AND SAVINGS

[In millions of dollars]

	Cost	Savings
Fy 1980	13.11	31.48
Fy 1981	15.79	36.51
Fy 1982	15.57	43.16
Fy 1983	18.81	48.29
Total	63.28	159.44

Mr. SALMOND. Ms. Johnson, can I add to that, please?

There is a Presidential order which provides that in existing structures we must reduce the energy usage by 20 percent by the year 1987, and we're already there.

Mrs. JOHNSON. Good.

Mr. SALMOND. And in new construction we are required to reduce energy usage by 45 percent. We're already there. I'd say the VA is a leader in this effort.

Mrs. JOHNSON. Good work. Thank you.

Mr. EDGAR. Any additional questions?

I have two additional questions.

Dr. Custis, did the Women's Advisory Committee within the VA get funded in the President's budget?

Dr. CUSTIS. Like so many other advisory bodies there's no separate funding for the Women's Advisory Board. It comes out of general medical care funds.

Mr. EDGAR. Last year this subcommittee conducted a nationwide survey reference to VA outpatient needs. The survey indicated that the local stations would need at least an additional $300 million to meet present outpatient demand. In your opinion, Dr. Custis, does the present budget reflect the Department of Medicine and Surgery's ability to meet the outpatient demand?

Dr. CUSTIS. I would of necessity have to qualify the question, if I may, in that we meet the service-connected demand. Where we have trouble and where there is a growing denial of entry into the system is in the nonservice-connected lower priority entitlements.

We are presently or have just completed a survey trying to get a measure of the magnitude of that denial of care to the nonservice-connected veteran. Strangely enough, our data-keeping system does not adequately track that, so that this survey that we just completed will also provide a baseline for monitoring in the future.

We expect that this, the growth of denial of care to the nonservice-connected is going to increase in significant proportions. We will be getting a measure of it and keeping track of it.

Again, the answer to your question is our current resources provide care for the service-connected. It provides less and less opportunity for care for the non-service-connected, lower priority.

Mr. EDGAR. Will the MEDIPP process give you some data on what your future demand is going to be?

Dr. CUSTIS. Yes, sir.

Mr. EDGAR. And would this budget be tracking that or is that for some future budget?

Dr. CUSTIS. The whole MEDIPP planning effort has a product that properly should be titled a needs assessment, and it is only indirectly related to budget construction. The fact that any given community has in their district a requirement based on a needs assessment isn't necessarily an insurance that it winds up in the following year's budget. But to answer your question, that's what MEDIPP is all about, so that budgets will be built on a greater degree of valid information.

Mr. EDGAR. We have an additional question from staff.

Mr. WILSON. Dr. Custis or Mr. Salmond, do either of you have in front of you a copy of the 5-year medical facility construction needs

assessment from 1984 to 1988? There's a sketch on front of it. Can you tell us what that sketch represents?

Mr. SALMOND. Mr. Wilson, I'm sure you're well aware of that.

Mr. WILSON. This is just a mean streak in me coming out but is this not a sketch of the proposed new Baltimore hospital?

Dr. CUSTIS. There will be a new edition coming out soon. [Laughter.]

Mr. WILSON. I'm sure it will be of Philadelphia. [Laughter.]

Mr. EDGAR. I think the question raises an interesting point and that is whoever's hospital sketch gets put on the cover, does that mean OMB will delete it? [Laughter.]

Dr. CUSTIS. Time magazine doesn't necessarily make the man of the year the most attractive person.

Mr. EDGAR. I just hope that in next year's centerfold that Baltimore and Philadelphia are included.

I want to thank you for your statements and your testimony. I appreciate your patience. We will be submitting to you some additional questions from additional members that we would like you to respond to for the record,[1] and we just appreciate your close working relationship with the Members of Congress who are interested in the quality and quantity of care which you try to provide with, in some cases, limited resources.

Dr. CUSTIS. Thank you, Mr. Chairman.

Mr. EDGAR. Thank you.

I'd like to indicate that the Paralyzed Veterans of America will submit a statement for inclusion in the hearing record. Without objection, we'll accept that.[1]

Mr. EDGAR. We'll now have a panel of witnesses representing the Blinded Veterans Association, the Jewish War Veterans, the Veterans of Foreign Wars, and the American Legion. Will they come forward at this point?

STATEMENT OF A PANEL OF WITNESSES: DAVID M. SZUMOWSKI, NATIONAL SECRETARY, BLINDED VETERANS ASSOCIATION, ACCOMPANIED BY JERRY MONROE, BRICKTOWN, N.J.; HARRIS B. STONE, NATIONAL EXECUTIVE DIRECTOR, JEWISH WAR VETERANS; JAMES N. MAGILL, SPECIAL ASSISTANT, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS; AND ROBERT E. LYNGH, DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. EDGAR. I'd like to share an apology to all of you for waiting through several witnesses this morning, but I hope that you've been enlightened by some of the responses as well as some of the line of questioning. I hope it's been as helpful to you as it has been to those of us on the committee, and I apologize for having you wait.

Also, before we begin, I'd like to congratulate the American Legion, particularly Bob Lyngh, who is here, for an excellent report that you did on Puerto Rico and that facility. Your work in reviewing health needs has been very helpful.

Let me now call on David Szumowski.

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[1] See p. 62.
[2] See p. 85.

Mr. SZUMOWSKI. Very good.

Mr. EDGAR. Is that pretty good?

Mr. SZUMOWSKI. Yes.

Mr. EDGAR. Not bad for a beginner. He's the national secretary of the Blinded Veterans Association. And let me indicate, all of your statements will be made a part of the record. I'd appreciate it if you could summarize and highlight your particular concerns as you see it.

STATEMENT OF DAVID SZUMOWSKI

Mr. SZUMOWSKI. Thank you, Mr. Chairman. My name is David Szumowski. I'm an attorney from San Diego, Calif., and together with Mr. Jerry Monroe, a businessman from Bricktown. N.J. We'd like to fill in for our national president, Tom Miller, who due to scheduling conflicts could not be here to present this testimony.

As you've indicated, our written statement highlights in much more detail our position on several issues, but briefly this morning I'd like to emphasize a couple of things to this committee. First and foremost is the MEDIPP process that was alluded to by Dr. Custis and members of your committee. I need not go into great detail as to what it is because this committee and most of us in this room understand a little about it. But, very briefly, this is a program that is designed to help meet the needs of the health care of veterans in the future by decentralizing the planning process to the local geographical areas wherein the services and the delivery system will be rendered.

As time goes on, not only are veterans getting older, but the World War II veterans are coming into an age where their health care needs are going to be much more significant and as the population of this country shifts geographically, it is more and more important that the needs of the shifting population be addressed by the facilities in the areas where they will ultimately reside.

Thus, the process is designed to have input from those who will receive the delivery of the service.

Now, I feel that this is important and on behalf of the Blinded Veterans Association we think it's vitally important in two ways. First, in the general sense, that as we as a country try to reduce the deficits that we face, it is reasonable to assume that many programs, including the Veterans' Administration budget, will feel the pinch and have some cutbacks. Naturally, part of that program is the health care delivery system.

And as the amount of dollars available to veterans in the health care system diminish and while the health care costs generally increase, we may find that a greater proportion of veterans who are not now making use of the system will turn to the Veterans' Administration system as part of their benefits for having served their country, and that could be for any number of reasons, not the least of which is raising of insurance costs for health care.

Now, on a smaller scale and of more particular importance to the Blinded Veterans Association, is how the planning process will be implemented to meet the needs of specific veterans, and I'm here to speak on behalf of blinded veterans, naturally.

The Blinded Veterans Association recently conducted a survey trying to find out how the MEDIPP process is actually working for grassroots input, and of the 28 medical districts in this country, we sent a letter to them asking them what they were doing and how blinded veterans were involved. Of the 28, only 20 responded to us. Of the 28, there were only 4, 4 medical districts, that had any form of structured MEDIPP planning process, and of those 4, only 2 involved blinded veterans in the input process. The other 2 said they had veterans groups that had input, but they did not have blinded veterans giving input.

Now, it's also interesting to note that 15 of the 28 medical districts said that they had no formal structure; yet 13 of those 15 indicated that they have left the responsibility for the planning process to the medical center directors under their jurisdiction.

It's also interesting to note in the response, a chart of which is in our written testimony, that the medical districts have been giving the medical centers some leeway to apprise the veterans community of the progress that they are making in the planning process.

I would submit to this committee that being apprised of the process is not the same as being involved at every phase of the planning stage. Now, with specific reference to the blinded veterans, as blind veterans get older, they are going to have health care problems that need specific attention, and some of it may relate to their eye condition. As World War II veterans and others, all of us, get older, whether we are blind or not, we must recognize that one of the disabilities that come with the aging process may, unfortunately for those who have sight, be some vision problems.

And we feel that we, in the BVA, are most experienced knowing what it takes to deal with problems related to blindness, how to service the health care needs of blinded veterans when those problems specifically relate to their vision problems, and how to rehabilitate them and deliver the services necessary for that.

Although we are blind, we can see that the sighted public and those members who are in control of decisionmaking can understand what blindness is about. In other words, we feel you all are educable. And we also feel you are trainable in understanding and emphasizing with what we need and how we can best serve the populations that we are charged with.

Therefore, what we would like to recommend to this subcommittee, in the discharge of your oversight responsibility in the Veterans Administration, is to work more closely with the VA, hold their feet to the fire, to try and get them to get a more formalized structure in the MEDIPP process, because right now, as I've indicated with the statistics, a great number of the medical districts are not aware of how to implement the MEDIPP process. Giving lip service to a program that is designed to help serve the future health care needs of the aging veteran population is all well and good, but if it gets down to the grassroots level and the medical center directors and the medical district directors haven't got the faintest idea of what this plan means or how to involve local veterans' groups or feel that merely apprising them of the progress without asking them for their input to help meet those future needs, therefore the program is going to fall of its own weight, if it doesn't have this kind of input.

And we think it is the responsibility of this committee and the work of other veterans' groups in working closely in a cordial and cooperative basis with the Veterans' Administration to try and put things into perspective and get a more reasonable evaluation process for the information by involving the local groups.

I'd like to switch my attention just briefly to the situation in Puerto Rico, some of which was alluded to earlier as well. First of all, we'd like to thank this committee for its support, and thank the members of the Veterans' Administration who have worked closely with us in trying to put forth a proposal for the construction of a 10-bed blind rehabilitation clinic in the San Juan area.

The $9 million is a considerable amount of money and it will provide the services that are needed. However, there are a couple of serious concerns which I'd like to mention and then my colleague, Mr. Monroe, will speak more fully on that.

The first concern is that the construction budget is for fiscal year 1985, if approved by Congress. Yet it does not include any funding for staff or equipment. That is not proposed until the 1986 budget, which puts the operational phase of this clinic and its opening well into the 1986 calendar year. Right now there are over 600 blinded veterans who need the care in Puerto Rico and need some rehabilation training, and because of cultural barriers, climate, and an unwillingness to leave their homeland, they will not travel to West Haven, which is the nearest facility that can offer the kind of services.

We do have a concern and we think we have a solution and I'd like Mr. Monroe to comment on that if he would, please.

Mr. EDGAR. I'll yield to Mr. Monroe. I just want to say that we are under some time constraint and I'd have to ask that you keep your comments as brief as possible.

Mr. MONROE. All right. Mr. Chairman and members of the committee, I thank you for this opportunity. But what I really want is the support and the help of this committee to encourage the VA to open up a temporary rehabilitation day care in San Juan, P.R. The lack of any accredited rehabilitation center in Puerto Rico makes it most difficult for our veterans from Puerto Rico to go to a strange area, which Mr. Szumowski mentioned.

We want a temporary opening of a rehabilitation center in San Juan so that we could take care of those cases presently while the construction of the nursing home is being made. It would also give us an opportunity to find the proper staffing, get the proper equipment, and then when the construction is all done, we would have a firstline staff to go in and make an operational system go good.

Now, I understand and we understand, rather, that the space that we need is available in San Juan. The VA Medical Center in San Juan has available the space that is necessary.

We would like this committee to tell the VA that this is an emergency that we need something to take care of, those cases right now that need attention. I wish that my words would meet your heart and not your ears only.

Thank you.

Mr. SZUMOWSKI. Mr. Chairman, my final two comments will be extremely brief, a matter of seconds.

The BVA would like to go on record as supporting the refunding of the renovation projects for the Philadelphia facility and any other Veterans' Administration facility which is in a sad state of repair. We think that with proper renovations that a great deal of cost could be saved rather than going to some new construction.

And my last comment is just to bring to your attention that there is a $10 million item in the budget for removing architectural barriers at VA facilities and less than 1 percent of that money in the fiscal year 1983–1984 budget went to helping overcome some of the barriers to the visually impaired, particularly in tactile number recognition and braille markings on elevators, and a significant number, more than the less than 1 percent, is that it happened only in one facility in this country, in Allen Park, and we think more attention should be paid by the VA toward getting the visually impaired a more substantial part of that budget.

If there are no other questions, Mr. Chairman, I'd like to thank you for allowing us to be here, and hope that we see most of this committee tomorrow as the Blinded Veterans Association recognizes Senator Jennings Randolph for the fine work that he has done on behalf of the blind and advising the BVA, and look forward to giving our full testimony on March 28 to a combined session of the House and Senate Veterans' Affairs Committees.

Thank you.

[The statement of Mr. Szumowski appears on p. 68.]

Mr. EDGAR. Very good. I appreciate the comprehensive nature of your statement, and if you'll just remain, if you can, we may have a question or two at the end of the panel.

Mr. Stone?

STATEMENT OF HARRIS B. STONE

Mr. STONE. Mr. Chairman, it's an honor for me to appear before you today on behalf of the Jewish War Veterans of the United States to discuss our views of the VA medical construction program for the fiscal year 1985. I will summarize our testimony.

Mr. EDGAR. Mr. Stone, the full text of your statement will be made a part of the record and we appreciate your summary.

Mr. STONE. We believe the Nation has a clear responsibility and commitment to maintain and upgrade the quality of the VA medical care system, and to meet the health needs of an ever-aging veterans population. In this regard, the budget request for fiscal year 1985 is not satisfactory, and we feel the VA must reestablish its priorities to insure the safety, modernization, and construction of sufficient VA facilities, and I think we all heard ample testimony today of where that's needed, by the failure to answer many of your very pointed questions.

We wholeheartedly support the proposed increase of $290.7 million to the $822 million budget authority for fiscal year 1985. These funding levels are barely adequate for the short term. Therefore, while we commend the VA's proposed $28.6 million 1,039-bed replacement for its hospital in Houston, Tex., we are most distressed that not a single new VA hospital has been proposed for fiscal year 1985. The administration has failed to reconsider its decision to

cancel plans to either renovate or modernize the Baltimore VA Medical Center.

The Baltimore VA Medical Center is considered by the VA to be 1 of the 10 medical centers most in need of construction, replacement, or major modernization, as the case may be.

In the area of nursing home care, we feel this budget request is inadequate to keep up with the continued expansion of veterans' needs. The budget for fiscal year 1985 is $16½ million lower, requesting only $50.8 million and an addition of only 57 nursing home beds over last year's request.

Furthermore, the budget for fiscal year 1984 marked the third year in a row in which funds were not authorized for the construction of new domiciliary facilities or remodeling existing ones. The VA's medical construction budget for fiscal year 1985 has barely addressed this most serious problem. In fact, the VA has chosen to renovate just one domiciliary facility. We urge this subcommittee to closely monitor this situation and to consider providing additional funds for domiciliary care in the medical center construction budget for fiscal year 1985.

All of these budgetary deficiencies will be magnified by current demographic trends in the veterans community. This subcommittee and our Nation's veterans organizations must respond to the realities of our time. Failure to resolve this dilemma because of a lack of budgetary planning by the Veterans' Administration and the Federal Government, and increased health demands of veterans, can only result in budgets that do not reflect or answer the growing concerns and needs of veterans across this country.

Finally, the last point to be made about this budget is more of an administrative problem than a budgetary deficiency. Last fall, on September 27, 1983, the House Subcommittee on Oversight and Investigations, of the Committee on Veterans' Affairs, investigated allegations made by the Association of Orthopedic Chairmen on the status of VA health care. In its summarized form, the major thrust of this report is that orthopedic care is in a perilous condition due to improper use of funds, unsafe operating conditions due to old or poorly maintained instruments, and to general mismanagement.

Mr. Chairman, even if this report is only partially accurate, I urge this subcommittee to once again monitor this situation and all similar reports to obtain an accurate picture of VA medical care.

To conclude, the Jewish War Veterans of the United States views this year's medical and construction budget as being barely adequate for the short run. While the VA has never been expected to care for all veterans, it must plan for the health needs of the service-connected, disabled, and needy veterans who are growing older.

Thank you very much, Mr. Chairman, for giving us the opportunity to express our views.

[The prepared statement of Mr. Zoldan appears on p. 72.]

Mr. EDGAR. Thank you for your testimony.

Mr. Magill?

STATEMENT OF JAMES MAGILL

Mr. MAGILL. Mr. Chairman, thank you for the opportunity to present the views of the Veterans of Foreign Wars with respect to the VA's construction program.

I would first like to state that we are generally pleased with the funding for medical construction for the next fiscal year. We believe the increase is needed and much deserved.

The replacement or modernization of several medical centers and the funding for the new VA nursing homes is much welcome.

We are, however, concerned with the lack of funding for the Baltimore and Philadelphia facilities. In each case there is a demonstration of need and justification, not to mention the amount already spent and with the Philadelphia facility having the availability of land at no cost.

Finally, Mr. Chairman, it appears things have not changed in Puerto Rico with respect to veteran health care, and again, it appears the answer we hear is to continue the present course of action. We must improve the condition of health care in this locale, not continue its present form.

This concludes my statement. I'll be happy to respond to any questions you may have.

[The prepared statement of Mr. Magill appears on p. 74.]

Mr. EDGAR. Mr. Magill, your statement was entirely too long. [Laughter.]

Mr. Lyngh?

STATEMENT OF ROBERT E. LYNGH

Mr. LYNGH. Thank you, Mr. Chairman.

The American Legion is pleased to have this opportunity to present its views on the subject of construction plans for the VA medical program for fiscal year 1985, and on the provision of health care services to the veterans of Puerto Rico and the Virgin Islands.

First, we should say we are, in fact, pleased and appreciative of the budget request for construction in the medical program for fiscal year 1985. We have reviewed the line item proposals for the use of these funds and we have no hesitation in saying they all appear necessary and justified to us, and we hope the committee will recommend their authorization.

Having stated our approval of the administration's funds request for fiscal year 1985, we wish to speak to the subcommittee about certain shortfalls we have identified in the proposed budget. We refer specifically to the replacement hospital for Baltimore and the clinical additional and nursing home care unit for VAMC Philadelphia.

The need for the replacement hospital at Baltimore is clear for all to see. The need was established, design and planning were completed, funds were appropriated, contracts let. Construction was, in fact, begun. Then the funds for Baltimore were listed in a rescission message from the President and suddenly the replacement hospital for Baltimore was canceled.

Our petition to the subcommittee is that its authorization be renewed and that construction go forward. The American Legion

strongly recommends that the Baltimore replacement hospital be constructed.

Then there is the matter of the additions and modifications for the Philadelphia VAMC. These too are badly needed.

What is needed at Philadelphia is completion of the clinical addition, the nursing home care unit, and parking facilities. The solution we see is for the House committee to recommend authorization for fiscal year 1985 and for funds to be appropriated in such a way that construction will, in fact, at least be underway before the end of 1986.

On the subject of delivery of health care services to the veterans of Puerto Rico and the Virgin Islands, we can first dispose of the Virgin Islands by saying that as far as we know the contract authority Congress has granted to VA for the Virgin Islands is working satisfactorily and assuring care needed to veterans.

I might allude to the fact that we have just become aware of the plan to establish an outreach center at St. Croix and the American Legion is certainly supportive of that.

The situation regarding delivery of health services to the veteran population on the island of Puerto Rico is a complex and difficult one. The American Legion, while crediting and commending what has been done so far to provide for Puerto Rican veterans, some further actions are required in addition to what is being done and planned.

An American Legion representative visited Puerto Rico on two occasions during 1983 and in doing so gained a fairly comprehensive understanding of the conditions that prevail there and impact on the delivery of benefits by the Veterans' Administration.

It would seem the bottom line of this presentation, in addition to the observations in the attached report, is that what is really needed at VAMC San Juan is a greater allocation of funds, permitting mainly an increase in the number of health professionals to care for the very heavy caseload that follows the population size and economic climate in Puerto Rico. The American Legion has so stated to VA.

The response received is the same as that received every time we submit similar recommendations about any other VAMC, which essentially amounts to the need is recognized but must be viewed in context with other system wide priorities. We know all about system wide priorities, Mr. Chairman. Through our field service we visit more than 65 VA medical centers each year and all of them have their share of problems.

We do believe, however, that some special consideration should really be given to Puerto Rico for the reasons stated in our letter to the Chief Medical Director of last April and which is attached to this statement.[1]

We hope the subcommittee will be able to give some special consideration to the problems and the needs of the veterans of Puerto Rico and once more we thank the subcommittee for the opportunity to be here today.

[The statement of Mr. Lyngh appears on p. 77.]

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[1] See p. 81.

Mr. EDGAR. Thank you very much and I want to thank all of you for your statements.

One thing that you could do for this subcommittee would be to, once again, thank many of the people who represent all of your organizations out in the six medical regions across the country. When we went across the country with our hearings, we heard testimony that was prepared by many of the regional and State directors, and some of the service officers representing all of your veterans associations. The quality of that testimony was very high and their support in our hearings was very good.

As Mr. Lyngh knows, particularly with the American Legion's visitation program, and as many others of you know, as you visit hospitals, when you visit 25 separate hospitals, you visit 25 separate hospitals. There is some commonality but they're all unique, they're all different, and in certain ways they all have different needs.

It was, indeed, helpful for us to see the tone and shape and flavor of those facilities, as we visited. We were able to get in to some specialized facilities for blinded veterans and we looked at some of the surgical needs that Mr. Stone's questions and commentary are important for us to make sure the quality of that surgery and acute care is there.

We looked at readjustment counseling centers, combat units, and psychiatric units. We looked at the medical equipment and its needs and its priority. I'm angry at myself for not asking Dr. Custis a few more questions this morning dealing with the adequacy of equipment in some of the facilities. I find that what we do is we cannibalize certain parts of the budget that aren't protected, in order to do other things within the facility, and one of my overall impressions is that the system has been cannibalized to the bone by limits on staffing, on cuts in some of the equipment that is essential for the keeping up of the quality of that care.

When we come up with new and innovative ideas that may, in fact, save money or save inpatient service, those have to be put on the back burner because they don't meet the budgetary priorities. I know each of your organizations is going to follow that during the course of the year.

To the Blinded Veterans Association, your recommendations will be taken under consideration by the members of this committee. We are pleased that in Puerto Rico they are moving on the 10-bed facility. We hear your suggestion related to getting the facility started sooner in temporary space. That's something that we can look at.

I know that there are some plans for some equipment that will be specifically located in the new facility and it would be difficult to buy some of the larger pieces of equipment and place them in a temporary facility. But some interim solution might be possible.

I can assure all of you that we're going to try to hold the feet of the VA very closely to the fire as it relates to Puerto Rico. They have requested a 2-year extension of their contracting services. My guess is that we will probably look at a 1-year extension again, simply to say that the services there are inadequate.

I can't overemphasize what we found in terms of the psychiatric care or lack of it that's being provided to Puerto Rican veterans, and we really have to move on that situation.

Let me just request all of you to be the oversight for us in your different associations and veterans organizations. You've done that in the past. You've brought to our attention problems and we look forward to working with you this year in making sure that we can continue to provide health care throughout the country, given the limitations of the budget.

I thank you for your testimony and I don't think there are any additional questions. Mrs. Johnson was intending to come back but let me conclude the hearings today.

The Subcommittee on Hospitals and Health Care now stands adjourned.

[Whereupon, at 11:47 a.m., February 23, 1984, the subcommittee recessed, subject to the call of the Chair.]

APPENDIX

STATEMENT OF HON. BALTASAR CORRADA

Mr. Chairman, members of the Subcommittee, I appreciate the opportunity to appear before you today to address the pressing need for the VA to develop a comprehensive plan leading to the offering of adequate health care to every eligible veteran in Puerto Rico.

At the outset, I want to thank Chairman Edgar and the Ranking Minority Member, Mr. Hammerschmidt for the interest they have placed in assessing and solving the deficiencies in the VA health care delivery system on the Island which has been recently evidenced by the bipartisan Subcommittee's staff visit to Puerto Rico. I also want to thank those who made the trip, namely, Jack McDonell, Rufus Wilson and Richard Fuller for the concern and sensitivity they displayed throughout their visit as well as their eagerness to learn more about the VA system on the Island which was not overshadowed by the fast paced and overburdened VA schedule which virtually left no time for them to appreciate the beauty of that part of the United States.

In my testimony today, I will refrain from once again burdening this Subcommittee with the facts and statistics which fully justify an aggressive and coherent initiative by the VA and Congress to remedy the deficiencies in the VA health care delivery system in Puerto Rico. Nevertheless, I will once again call your attention to the 1978 GAO report which portrayed a VA health care delivery system in Puerto Rico in urgent need of additional resources to enable it to deliver proper medical attention to eligible veterans there and which was dependent on private suppliers of health care in Puerto Rico which in the area of psychiatric care offer inadequate facilities and services in most cases and below the standards of the VA in the others. As you know, these findings were ratified by the VA in two separate reports to Congress presented in April 1981 and January 1983 and currently remain unchanged.

I was certainly pleased to see the inclusion in the VA Budget for fiscal year 1985 funds for the construction of a 120 bed nursing home and a 10 bed blind rehabilitation center in Puerto Rico which I am confident Congress will approve.

Presently, there are no VA nursing homes in Puerto Rico and the VA contracts 50 beds for our senior veterans. There are 13 non-VA nursing homes on the Island with a bed capacity of 987 of which all but few are below VA standards. This means that there are 5.9 beds per 1,000 inhabitants over 65 years of age in Puerto Rico as compared to 65.9 beds per 1,000 persons over 65 years of age in the U.S. mainland. In 1980 there were 13,000 veterans over the age of 65 in Puerto Rico and by 1990 it is estimated that this number will soar to over 33,000.

I urge this Subcommittee to assume a role of leadership and rescue the thousands of ailing veterans in Puerto Rico who every year suffer inadequate health care services due to insufficient VA health care facilities on the Island. The nursing home and the blind rehabilitation center are only two of the sorely needed facilities the VA needs to have in order to properly address the health care needs of every needy eligible veteran in Puerto Rico. The construction of a 480 bed psychiatric wing in the VA Medical Center in Río Piedras, an out-patient clinic for the southern part of the Island and the expansion of the out-patient clinic in Río Piedras are also critical for the VA to be able to offer quality health care to all eligible veteran on the Island. A comprehensive plan needs to be enacted now if the veterans in Puerto Rico are to receive quality health care by the end of the decade.

Since I came to Congress in 1977, I have been a strong advocate of bringing equality to the Puerto Rican veterans under VA programs. My number one concern has been to secure for our veterans on the Island, the same quality of health care those veterans living on the mainland receive. There efforts and sacrifices on behalf of our democracy and freedom were no different. We Puerto Ricans are always willing

to serve gallantly and proudly in the U.S. Armed Forces and we have without reluctance proven our loyalty to the United States in various battlefields since we become American citizens during World War I. Our commitment to the ideals of this great Nation has been highlighted by thousands of Puerto Rican casualties in U.S. wars and a similar commitment from the VA to heal the wounds and ease the pains of Puerto Rican veterans is a fitting and natural response to their deeds.

The VA health care delivery system on the Island is 20 percent underfunded and 20 percent overworked. The bottom line, Mr. Chairman, is that the veterans in Puerto Rico have never received in the past, and are not receiving in the present and if something is not done promptly will not for many years to come receive the quality medical attention they have so rightfully earned.

I also would like to address today a situation which has caused me great concern given the potential adverse impact it may have on the lives of mentally disabled veterans in Puerto Rico. I recently learned that the VA is assigning rating jurisdiction in psychiatric claims from Puerto Rico to the Winston-Salem Regional Office. New and reopened claims and claims for increased evaluation of psychiatric disabilities would be subjected to this new procedure which also includes a review for acceptance of the report of examination by the VA central office prior to being sent to the Winston-Salem Regional Office for rating.

I understand that what triggered the new rating procedures is the fact that in Puerto Rico there are two and one half times as many veterans service-connected for psychiatric disabilities than in the rest of the country and four times as many rated totally disabled from these disabilities.

Even though I believe fraud, abuse or errors in federal programs should be eliminated where they exist, I object the new rating procedures. I believe this new procedure is discriminatory, ill-advised and open to challenges for the due process violations.

Statistics in this case reflect a disparity between U.S. mainland veterans and Puerto Rican veterans but do not necessarily indicate that such disparity is based on fraud, abuse or error. The higher incidence of mental health problems among Puerto Rican veterans portray the reality that these veterans, given the different culture, idiosyncrasy, lifestyle, and language, coupled with the economic distress of the Island and the extreme population density of Puerto Rico suffer from conditions that bear heavily on their mental health.

First, mental health problems occur at a higher rate in Puerto Rico than on the mainland not only among veterans but also among veterans but also among nonveterans. This has been attributed in part to the over population the Island experiences. Our population density of approximately 940 persons per square mile is by far higher than that of any state except for New Jersey. This situation by itself exacerbates the propensity of any community to suffer mental disorders.

Secondly, Puerto Rican veterans not only have to contend with the horrors of war and its lingering effects but also with the cultural shock their lack of proficiency in the English language precipitates. The language barrier also precludes the Puerto Rican soldier from assuming skilled positions in the Armed Forces, forcing the vast majority to become infantry men, a position which demands a higher degree of sacifice and stress. In addition, the Puerto Rican veteran, also due to his lack of proficiency in English, is normally precluded from fully benefitting during times of war from the highly helpful counseling program which is usually offered in English.

Third, mental health services are available to veterans from other sources in the U.S. mainland but such services are limited in Puerto Rico. A major factor contributing to this situation is that Medicaid applies to Puerto Rico on a very limited basis with the federal government providing only $45 million while the Puerto Rican government provides over $140 million. Furthermore, with a level of unemployment in excess of 20 percent and many other underemployed, Puerto Rican veterans do not have the same access to private health insurance programs paid by their employers.

Fourth, the law requires that if a veteran is hospitalized for service-connected pyschiatric reasons for a period of at least six months, the veteran claim for a 100 percent disability rating must be approved. As it is well known to the Subcommittee approximately 70 percent of the in-patient psychiatric care in Puerto Rico is contracted with institutions that offer services and treatments well below the VA standards and with lengths of stay at least four times that of the VA hospital in San Juan. I believe this situation could be solved by having the VA assume full control of all psychiatric cases through the construction of the psychiatric wing in the San Juan area. This will assure the VA that proper treatment modalities are used in every case and therefore over extended stays would be eliminated.

Another concern I have regarding the new rating procedures is that they lack the guarantees of due process the regular procedures have. The new procedures requires the board in San Juan to only conduct a hearing with no further involvement in the decision making process and then the case would be transferred to Winston-Salem for a rating board there to make a final decision based on the record of the hearing they never attended. The basic principle of due process would be shattered. This principle calls for a day in court for every claimant offering him or her the opportunity to argue his or her case before the person(s) judging the same as well as giving the person the opportunity to answer any concerns or questions the judge(s) may have. In addition, the hearing record would have to be translated and thus the impact of the testimony could be weakened or misinterpreted. Also the rating process would be substantially delayed. Through this new rating procedure the veterans in Puerto Rico would be surrendering highly important rights and will never face the real judges of his or her claim.

In addition, this new procedures seriously questions the capacity of the rating board in San Juan to make sound decisions at a time when its record of allowed and disallowed appeals before the Board of Veterans Appeals is similar to that of Winston-Salem. By singling the San Juan rating board for this new procedure, its credibility to say the least could be weakened.

Mr. Chairman, in closing I urge you to join my efforts to reverse the VA decision establishing temporarily new rating procedures for Puerto Rico or to terminate such new procedures immediately and to continue your efforts to promptly secure a comprehensive plan from the VA leading to the offering of the quality health care every needy eligible veteran in Puerto Rico has earned.

Prepared Statement of Hon. Ron de Lugo, Delegate, the Virgin Islands

Mr. Chairman, I would like to thank you and members of your Subcommittee for this oportunity to testify on behalf of the health care needs of veterans in Puerto Rico and the Virgin Islands. I am disappointed that the report, as did the previous reports, had very little to say about health care for veterans in the U.S. Virgin Islands. While I can understand (as the report points out) the concern for more health care facilities for areas on the mainland having a large veteran population, the needs of Virgin Islands veterans should also be appreciated. Virgin Islands veterans have served in no less wars and they certainly should receive no less medical service.

Mr. Chairman, I reiterate my position from previous testimony, that the position of medical care ombudsman should be established with the medical facility in Puerto Rico, and staffed by a Virgin Islands veteran to coordinate the arrangement of appointment, logistics and communication between that facility and veterans in the U.S. Virgin Islands. A second option would be for satellite outpatient clinics in the Virgin Islands, including Veterans Administration Benefit Counselors for St. Thomas and St. Croix. This is necessary, Mr. Chairman, because a more authoritative VA presence is needed in the U.S. Virgin Islands.

I am grateful for your interest in the health problems encountered by veterans in Puerto Rico and the Virgin Islands as demonstrated by the efforts in making sure that the Virgin Islands was included in the recent visit by Committee and VA personnel to Pueto Rico and Virgin Islands. I thank you for sharing with us the announcement of a new outreach station soon to be opened in St. Croix. Possibly as an interim step, Veterans Benefit Counselors could be assigned to the outreach stations on each island to assist veterans with their health care needs.

I cannot understate the importance of accessible health care for Virgin Islands veterans.

The numbers of veterans in the Virgin Islands may seem insignificant in comparison to the needs of larger populations, but there is a duty to extend services in a meaningful way and the expectation tha this will occur.

I thank you on your attention to my concern in this matter, Mr. Chairman, and I ask for your continued support in upgrading the health care for the Virgin Islands.

Statement of Donald L. Custis, M.D., Chief Medical Director, Veterans' Administration

Mr. Chairman and members of the subcommittee, I am pleased to appear before you this morning to present the Department of Medicine and Surgery's medical facility construction request for fiscal year 1985. With a request for new budget authority that approaches a total of $822,000,000, this fiscal year 1985 construction

program and our request for project authorization by the committee, as contained in volume VI of the congressional submission, is by far our most ambitious plan to date. Before describing the fiscal year 1985 construction program and its development, I would like to describe the magnitude of the VA health care system and the construction planning environment.

The VA health care system is made up of 172 medical centers, 101 nursing home care units, 16 domiciliaries and 53 independent and satellite outpatient clinics. This system operates in over 5,000 separate buildings, with over 100 million square feet of space. As you can see, we have a tremendous capital investment represented by these buildings. However this capital investment is aging. Over 53 percent of our hospital beds are in buildings which are over 30 years old. The majority of our VA medical centers were constructed without the capability to expand to meet the increasing need for outpatient care. Construction standards used did not reflect the requirements stipulated in today's life safety codes, nor did they sufficiently provide for a barrier-free architectural design for the handicapped patient. While improvements to the physical structure of these buildings have been made in the past, a great deal remains to be done. Maintenance of a quality VA health care system requires a continuing commitment to a capital investment program which preserves and protects facilities and provides improvements to keep pace with modern, state of the art medical practice. Our capital improvements program must also provide facilities to respond to the changing needs of our veteran population—an aging population that is rapidly migrating to the Sun Belt areas of the country.

The construction budget request for medical projects includes a major construction program level of $730,220,000. This reflects $120,000,000 in reprogrammings from prior appropriations made available because of the favorable bidding climate the construction industry has been experiencing of late.

Under the major program, we are requesting approval for 53 construction projects, additional funding for one project, $17,000,000 for the advance planning fund, $25,000,000 for asbestos abatement projects, and $5,220,000 for energy conservation projects. This major program request also includes a proposal to initiate a "design fund". This "design fund" will enable the VA to proceed directly into the working drawing phase of construction project development, thereby saving the significant amount of money associated with the current delay between completion of preliminary drawings, and working drawing contract award for the project. The estimated savings from reduced inflation and design changes will be $34 million in fiscal year 1985 alone.

This major program request represents a balanced approach to correcting existing deficiencies and providing for needed improvements at the health care facility sites. As depicted in the request, we are requesting authorization for 5 replacement/modernization projects, 7 nursing home care units (including a building conversion at West Los Angeles VA), 1 domiciliary, 1 research project, 6 outpatient improvements, 13 clinical improvements, 5 electrical projects, 6 fire and safety improvements, and 8 projects categorized as general projects.

Our minor construction program request for medical projects is $149,420,000. We expect to fund approximately 60 minor projects in the range of $400,000 to $2,000,000 in estimated costs and 200 minor miscellaneous projects in the range of $100,000 to $400,000 estimated costs.

The fiscal year 1985 construction budget request represents the culmination of many planning and development efforts. The projects which were ultimately included in the request had been identified in the Department of Medicine and Surgery's facility planning process, included in the agency's annual submission of the five year medical facility construction needs assessment to Congress, and developed through the advance planning fund process. An extremely important factor in determining the projects to be included in the fiscal year 1985 request was the impact of the medical district initiated program planning (MEDIPP) process. This process, initiated in 1981, completed its first full cycle in the spring of 1983. This grass roots planning process provides for a comprehensive assessment of current capability to meet future demand for health care services and includes plan strategies for meeting that future demand. The heart of this planning effort is a valid analytic base which projects program needs in the future and supports resource allocation efforts to achieve these program goals. MEDIPP projections of inpatient and outpatient workloads, mission changes, and new program requirements provide primary input to the construction planning process. Construction strategies are proposed within the district MEDIPP submission and these strategies are integrated into an overall VA systemwide construction program. Because of the lead times associated with major construction projects, those in the 1985 budget were being developed before the first MEDIPP plans were approved. Thus, the 1982 MEDIPP cycle provided for

the validation of programmatic requirements used in the development of each major construction project. Analysis showed that all projects in this budget request were supported by the MEDIPP data. The VA's fiscal year 1986 construction budget request, will be more significantly impacted by the MEDIPP process because the MEDIPP programmatic requirements will have been used from the beginning of the development process for these construction projects.

I know of the committee's concern for meeting the health care needs of the eligible veterans in the Commonwealth of Puerto Rico and the Virgin Islands.

The VA is proposing in the fiscal year 1985 request to construct a 120-bed nursing home care unit and a 10-bed blind rehabilitation center at the VA Medical Center, San Juan. In addition, we plan to continue to contract nursing home care beds for an average daily census of 50.

Medical District No. 3, including the Medical Center in San Juan, submitted their MEDIPP plan in November 1983. Although many needs identified in the MEDIPP submission are supported with quantitative justifications, plans to implement improvements in Puerto Rico must compete with all others for funds.

Results of the Central Office review of the 1983 medical district plans will be completed in the spring of 1984. The specific resource needs in Puerto Rico and the Virgin Islands will be evaluated in light of the needs determined through MEDIPP for the other hospitals and health care delivery programs within the VA system.

Mr. Chairman, in closing, the fiscal year 1985 construction program represents a corrective and improvement effort that is a vital component of the VA's health care delivery system. We ask for your continued support in our effort to provide for the health care needs of our Nation's veterans.

I would be pleased to answer any questions that you may have.

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VETERANS' ADMINISTRATION,
OFFICE OF THE ADMINISTRATOR OF VETERANS' AFFAIRS,
Washington, D.C., February 14, 1984.

Hon. BOB EDGAR,
Chairman, Subcommittee on Hospitals and Health Care,
House of Representatives, Washington, D.C.

DEAR BOB: This is in reference to your inquiry concerning the Veterans Administration's construction plans for the Philadelphia VA Medical Center.

We were unable to include design funds for this project in our fiscal year 1985 budget request to Congress. As often happens in the budgetary process, funds were limited and other large projects judged in need of construction, replacement or major modernization, were determined to be of higher priority.

This project will be considered for the fiscal year 1986 construction request for design funds and the fiscal year 1987 request for construction funds. To answer your question, if design funds were made available by the Congress for the Philadelphia project in the fiscal year 1985 budget, the VA would be able to proceed on schedule with the contract of this project.

Your continued interest and support are appreciated.

Sincerely,

HARRY N. WALTERS, *Administrator.*

VETERANS' ADMINISTRATION,
OFFICE OF GENERAL COUNSEL,
Washington D.C., April 12, 1984.

Hon. BOB EDGAR,
Chairman, Subcommittee on Hospitals and Health Care,
Committee on Veterans' Affairs, Washington, D.C.

DEAR MR. CHAIRMAN: Enclosed are the Agency's responses to the questions submitted following the Subcommittee's hearing on February 23, 1984, concerning the Department of Medicine and Surgery construction, MEDIPP status and resource allocation planning; and Puerto Rico and Virgin Islands health care plans.

I appreciate this opportunity to provide this information for the record.

Sincerely yours,

JOHN P. MURPHY, *General Counsel.*

Enclosure.

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSE

CHAIRMAN EDGAR TO VETERANS' ADMINISTRATION

Question 1. Priorities for State home construction projects had traditionally been set by awarding grants in the order in which the applications were received. Based upon a GAO recommendation, the priority list for State home construction projects was reviewed for any projects that warrant a higher priority to meet VA programmatic needs as identified by MEDIPP.

a. Has MEDIPP provided you with the kind of information necessary to improve the old method of setting priorities?

Answer a. A task force established to identify an improved process for state home construction funding concluded: (1) that bed producing projects could be prioritized based on need as determined by MEDIPP; (2) life safety projects could be prioritized by evaluating deficiencies and their potential hazard; and (3) patient environment and other projects could be prioritized by considering age and condition of facilities, and number of beds involved.

Question b. Have you changed your method of setting priorities?

Answer b. No. To do this the current policy of awarding grants in the order received based on the need of veterans as determined by the states would have to be changed to a priority determination based on the needs as determined by the VA. This change would require congressional action. After considering the advantages and disadvantages of whether to propose legislation to change our current policy we recommend that no change be made.

Question c. How many applications did you fund last year and how many do you expect to fund this year?

Answer c. During fiscal year 1983, five grants were awarded. To date expected to be awarded before the end of the year.

Question d. What percentage of the eligible applications will this fund?

Answer d. Currently there are 48 preapplications on hand for a total of $122,947,000. If the ten grants are awarded, the unfunded balance will be reduced by approximately 26 percent.

Question e. How much would be needed to fund all eligible applications?

Answer e. At the end of fiscal year 1984 there will be 38 unfunded projects requiring a total of $84 million for which preapplications have been received, 13 as early as fiscal year 1981. An appropriation of $34.5 million in fiscal year 1985 will provide 41 percent of the funds required to approve grants for these projects.

Question 2. Section 209 of S. 1388 authorizes VA to use $25 million for its working reserve fund, with certain restrictions, to undertake working drawings for construction projects before they are approved or funded by the Congress. In the fiscal year 1985 budget, the VA requests $20 million in new budget authority for a "design fund" to accomplish the same purpose.

a. Are these two actions duplicative?

Answer a. No.

Question b. If both are approved, will you use both? Will you fund $45 million of final design work, $25 million with restrictions of S. 1388, or $20 million.

Answer b. Yes, we will use the $25 million with the restrictions, for design of the projects in the fiscal year 1985 budget, and the $20 million as proposed in the fiscal year 1985 budget request for design of fiscal year 1986 projects not yet identified.

Question c. Please provide a listing of the projects whose final design work will be funded from either of the above sources.

Answer c. Projects to be funded from the fiscal year 1984 design fund pilot program will be from the attached list. A list for the 1985 proposed $20 million for the fiscal year 1986 projects is not yet available.

FISCAL YEAR 1984 DESIGN FUND PROJECTS

Albany, New York.—Modify Wards.
Alexandria, Louisiana.—Clinical Improvements.
*Alexandria, Louisiana.—120-Bed Nursing Home Care Unit.
Amarillo, Texas.—Addition and Renovation of Clinical Support.
*American Lake, Washington.—Laundry Replacement.
Big Spring, Texas.—Electrical Distribution System.
Boise, Idaho.—Geothermal Conversion.
Boston, Massachusetts.—Fire and Safety Improvements: Sprinklers.
Brockton, Massachusetts.—Renovate Building 8 for Patient Privacy, Fire and Safety, and Seismic.

Brockton (West Roxbury), Massachusetts.—Outpatient Addition, Research and Education, Administration.
Buffalo, New York.—Research Building and Clinical Expansion.
Cheyenne, Wyoming.—Expand and Renovate Building 1 for Clinical Functions.
*Chillicothe, Ohio.—Renovate Building 1 (Modernization Phase III).
Clarksburg, West Virginia.—Clinical Addition and Alterations.
Coatesville, Pennsylvania.—Fire and Safety Improvements.
Dallas, Texas.—Upgrade Primary Electrical Distribution System.
Danville, Illinois.—Renovate Building 14 for Administration.
Durham, North Carolina.—Clinical Addition.
Durham, North Carolina.—120-Bed Nursing Home Care Unit, Research Administration and Geriatric Research Education and Clinical Center.
Fresno, California.—Clinical Addition.
Grand Island, Nebraska.—Fire and Safety Improvements, Air Conditioning, Patient Privacy and Support Systems.
Grand Junction, Colorado.—Outpatient and Clinical Addition.
Hampton, Virginia.—Fire and Safety Improvements.
Hines, Illinois.—40-Bed Long Term Spinal Cord Injury Building.
Iowa City, Iowa.—Ambulatory Care and Clinical Addition.
Lexington (Cooper Drive), Kentucky.—Clinical Addition.
Long Beach, California.—160-Bed Spinal Cord Injury Unit and Spinal Cord Injury Outpatient Clinic.
Long Beach, California.—Construct Supply Warehouse.
Los Angeles, California.—Outpatient Clinic Building.
Louisville, Kentucky.—Clinical and Education Addition.
Lyons, New Jersey.—Renovate Building 4 for Intermediate Care.
Lyons, New Jersey.—Fire and Safety Improvements.
Marion, Illinois.—Seismic Corrections.
Murfreesboro, Tennessee.—120-Bed Nursing Home Care Unit.
Omaha, Nebraska.—Electrical, Fire and Safety Corrections.
Palo Alto (Palo Alto Division), California.—Spinal Core Injury Addition.
Pittsburgh (Highland Drive), Pennsylvania.—Fire and Smoke Detectors, Modernize HVAC, Secondary Electrical System.
Prescott, Arizona.—120-Bed Nursing Home Care Unit.
Providence, Rhode Island.—60-Bed Nursing Home Care Unit.
San Francisco, California.—120-Bed Nursing Home Care Unit and Parking Garage.
San Juan, Puerto Rico.—120-Bed Nursing Home Care Unit and 10-Bed Blind Rehabilitation Center.
Sheridan, Wyoming.—Outpatient Clinic Addition.
*Shreveport, Louisiana.—Ambulatory Care Addition and Linear Accelerator.
*Shreveport, Louisiana.—Upgrade Primary Distribution System and Elevators.
St. Louis (Jefferson Barracks), Missouri.—Laundry Replacement.
*Tampa, Florida.—Radiation Therapy.
Topeka, Kansas.—Electrical Corrections, Primary and Secondary.
West Los Angeles, California.—117-Bed Nursing Home Care Conversion.
West Los Angeles, California.—Renovate Building for Domiciliary.

*To be designed by the Office of Construction.

Question 3. The fiscal year 1985 budget includes $11.7 million to renovate buildings at the West Los Angeles VA Medical Center for use as a domiciliary. In addition, the 5-year plan for 1984-88 lists 11 other domiciliary projects at an estimated cost of $166.2 million.

a. Will the West Los Angeles project add any new beds to the 400 existing domiciliary beds?

Answer a. The West Los Angeles project is a planned renovation of existing domiciliary buildings and upon completion there will be a total of 300 domiciliary beds at West Los Angeles.

Question b. What is the mission of the domiciliary program? Do the 16 existing domiciliaries provide similar services to similar patients?

Answer b. The mission is to provide minimal care on an ambulatory self-care basis for veterans disabled by age or disease who are not in need of acute hospitalization and who do not need the skilled nursing services provided in nursing homes. This program is designed to restore and rehabilitate veterans in anticipation of their return to the community in self-sustaining and independent living situations or to assist veterans to reach an optimal level of functioning in a protective environment. Each of the 16 VA domiciliaries is tasked with the mission.

Question c. Have you developed a bed protection model for domiciliaries? If so, please describe it. If no, do you plan to?

Answer c. A Domiciliary Bed Projection Methodology is presently in place and has been utilized by the Department of Medicine and Surgery's 28 medical districts in determining domiciliary need for the 1982 and 1983 planning cycles under Medical District Initiated Program Planning (MEDIPP). The domiciliary methodology is a population-sensitive model that incorporates the current workload generated by domicilary patients in both VA and state home facilities, and also recognizes the potential workload estimated to be present in the noninstitutionalized populace. Current age-specific utilization rates are applied to the estimated veteran population for the planning horizon years of 1990, 1995, and 2000, to arrive at the future domicilary demand. The potential domicilary program workload is subsequently compared with existing VA and state home facilities to determine unmet need and formulate plans for addressing the deficit.

Question d. What guidance have you given district planners on how to estimate domiciliary beds for 1990? What are those needs, by district?

Answer d. Medical District planners are required to utilize the domiciliary methodology in arriving at projected needs for the planning horizon years. Planners are given latitude to incorporate adjustments to the methodology when specific district experience dictates. Any unsatisfied domicilary need is to be addressed by utilizing intradistrict domicilary resources, both VA and state; through interdistrict planning; and also through evaluating available alternatives to domiciliary care.

VA DOMICILIARY BEDS—1990

[Total beds—7,943]

Medical district	Beds	Medical district	Beds	Medical district	Beds	Medical district	Beds
1	0	8	500	15	135	22	599
2	406	9	344	16	400	23	285
3	75	10	206	17	163	24	72
4	565	11	0	18	149	25	233
5	195	12	482	19	232	26	300
6	440	13	317	20	590	27	200
7	400	14	175	21	78	28	402

Question e. What role will the domiciliaries run by State Veterans Homes play in meeting the projected needs in each district where State domiciliaries exist?

Answer e. State Home domiciliaries are considered a supplement to VA domiciliaries in meeting the projected needs in each VA medical district where State Home domiciliaries exist.

Question 4. What is your evaluation of the MEDIPP process after two planning cycles? Do you rely upon it to determine DM&S plans? What plan is used for requirements beyond the 5-Year construction plan?

Answer 4. We are very pleased with the MEDIPP process. The resulting plans provide us with information which has not previously been available concerning the current and future needs of the health care delivery system. MEDIPP is used to determine DM&S plans. It is reviewed by Facility Engineering, Planning and Construction in the maintenance of 5 year plans, and the 5 year plans are also reviewed during the preparation of MEDIPP plans. Requirements beyond the 5 year plan are based on the future workload projected through MEDIP needs assessment models.

Question 5. Please provide a chart detailing the number of permanent positions, by grade, for the Office of Construction. Why are so many positions at the GS 11-15 level in this Office? How many, if any, reductions at this level will occur due to the government-wide plan to reduce grades at this level? If you are not losing any, i.e. no downgrades will occur, please explain why.

Answer 5. Positions at the GM-15 level are occupied by service and staff office directors. GM-14 positions are division chiefs and resident engineers in charge of on-site supervision at the VA's largest construction projects. The number of GS 11-13 positions reflects the nature of the Office of Construction staff, which has a high percentage of professional employees, e.g., architects and engineers. The journeyman level for these positions is grade 13. The Office of Construction has no specific numerical goal for grade reduction, however, whenever vacancies occur at higher levels, the positions are reviewed for proper classification. As an example, the

review of the position of a director who recently retired resulted in lowering the grade from a GM-15 to a GM-14.

In addition, the Office of Construction has a very active recruiting program to fill vacancies at the lowest practicable level.

The attached detail of permanent positions was prepared as part of the 1985 budget submission. It has been revised to show the grade reduction in the director's position described above.

VETERANS ADMINISTRATION, OFFICE OF CONSTRUCTION, DETAIL OF PERMANENT POSITIONS

	1983 actual	1984 estimate	1985 estimate
ES-6			
ES-5	1	1	1
ES-4	4	8	8
ES-3	4		
ES-2	1	1	1
ES-1			
Subtotal	10	10	10
GS/GM 15	20	19	19
GS/GM 14	77	76	76
GS/GM 13	278	287	292
GS-12	88	85	93
GS-11	39	37	38
GS-10	1	1	1
GS-9	26	26	26
GS-8	6	9	8
GS-7	45	36	39
GS-6	54	61	60
GS-5	42	45	44
GS-4	18	19	18
GS-3	3	1	1
GS-2			
GS-1			
Subtotal	697	702	715
Total, permanent positions	707	712	725
Unfilled Positions, end of year	16	0	0
Total, permanent employment, end of year	691	712	725

Question. 6. What is the status of the DRG type methodology of allocating funds? Are there plans to recognize the veteran population migration patterns to the South?

Answer 6. The DRG methodology for allocation of funds to VA medical centers is in the process of implementation for the fiscal year 1985 target allowances. In the first year, very narrow caps on resource allocation changes are being applied. This cautious approach is dictated by several factors. The methodology represents a major change in incentives, the medical centers are being given ample time for managerial and clinical accommodation to these new incentives. Further, the addition of similar methodologies for ambulatory care and long term care will enhance the overall system performance and ameliorate some of the problems with the VA's cost distribution system used in determining the resource base for case mix measurement.

The resource allocation model is workload rather than population based. The MEDIPP program, in conjunction with the rest of the strategic management process, specifically takes into account migratory patterns of the veteran population. However, the resource allocation model in its current form, will allocate a greater proportion of the VA's Medical Care Appropriation to areas that are currently under the average cost with respect to their workload and funding bases. In general, therefore, a greater proportion of the resources will be allocated to "Sun Belt" facilities where workload and bed occupancy rates are high, lengths of stay are short, and significant rationing of services is occurring.

Question 7. What alternatives are being pursued to reduce costs of construction and to avoid overbuilding in the long term? For example: leasing existing medical facilities; building less expensive, less capable outpatient clinics with an improved referral program; sharing facilities with other Federal or private sector medical establishments, or expansion of mobile outpatient clinics and the traveling specialist program.

Answer 7. Through the MEDIPP process, many initiatives including those you mention are being pursued by the VA which will reduce construction costs by reducing the need for hospitalization and/or new construction. We are also emphasizing the development of new and innovative approaches to caring for increasing numbers of veterans in noninstitutional settings. Medical Districts are already utilizing many health care delivery options which include Adult Day Health Care Centers, Residential Care, Respite Care, increased sharing, and Mobile Outpatient Clinics.

Question 8. Last year, Dr. Custis testified that research at the Ann Arbor Veterans Administration Medical Center to develop a surgical management information system would be completed by April 1984. Is the research still on schedule? What utilization standard will you be incorporating into the new surgical criteria for construction projects?

Answer 8. Our efforts to develop a new surgical management information system have not proceeded as rapidly as originally expected. The development of an acceptable study protocol and the securing of funding to conduct the study has been ongoing. The Ann Arbor VA Medical Center has currently submitted a proposal to VA Central Office for funding. This proposal is under consideration, and it is expected that our resource allocation committee will reach their decision within the next few weeks. The Ann Arbor VA Medical Center staff in concert with the University of Michigan have begun by building an information system in support of the proposed effort. We would expect, however, that once the funding issue is resolved the final completion of the study will take an estimated 18 months duration. The utilization standard which will be adopted as a result of this study can not be determined at this time.

Question 9. During our Subcommittee's field hearings in the six Medical Regions last year, we heard many complaints concerning the lack of adequate funds for procurement of medical equipment (capital equipment allocations). Do you consider the fiscal year 1985 budget equipment with the Department of Medicine and Surgery? What is your plan (5 years) to alleviate this shortfall in equipment funding?

Answer 9. For the past few years the Department has requested a level of resources for medical replacement equipment (Object Class 31) equal to 50 percent of the total yearly replacement requirements. Funding replacement equipment at this rate would stabilize equipment backlogs at a manageable level. The requested level, however, included in the last two budget submissions (1984 and 1985) to Congress were at a 39 percent application rate.

Furthermore the budgeted level of equipment is ultimately eroded by complete or partial absorptions of unfunded requirements such as increased pay needs (e.g. pay raise, wage board, federal employees health benefits, social security, etc.), mandated legislation (e.g. PL 98-160) and high priority programs (e.g. acceleration of the decentralized hospital computer program). If the Medical Care appropriation is approved for a level of funding sufficient to pay for these costs (that have traditionally been absorbed) and if future equipment budgets are not reduced before transmission to Congress, resources planned and applied at 50 percent of total replacement needs would be adequate to meet medical center needs.

Question 10. When will the final action to lease a facility for an outpatient clinic in Ponce be completed? Why is it taking so long?

Answer 10. The project is proceeding on schedule. The space requirement were finalized during February 1984. We anticipate advertising for clinic space during April 1984. Clinic activation is scheduled for May 1986.

Question 11. In consideration of the Puerto Rico family tradition of taking care of elderly family members in their homes, why was the nursing home care unit placed in priority ahead of an expanded psychiatric science facility?

Answer 11. The need for nursing home care beds in Puerto Rico has been clearly identified and a project for a 60 bed NHCU was included as early as the fiscal year 1981-1985 Five Year Medical Facility Construction Plan. Subsequently, MEDIPP demonstrated a need for an additional 60 beds. The current MEDIPP review cycle is examining the issue of the appropriate number of psychiatric beds needed by the veteran population of Puerto Rico. When this issue has been resolved, appropriate bed projections will be included in the major project to modernize the medical center. This project is included for design in fiscal year 1987 as part of the current fiscal year 1984-1988 Five Year Medical Facility Construction Needs Assessment.

Question 12. Can you provide us with the VA system for management of quality of care reviews and the adequacy of internal controls concerning the Puerto Rican contract hospitals?

Answer 12. VAM&ROC San Juan, PR has established a Psychiatric Intervention Center (PIC) in the admissions area of the Medical Center. This Center was established to assist the Medical Center in improving the quality of care of our veterans with psyciatric problems, assuring that all admissions to contract facilities are necessary and that all patients presently in contract facilities are in the proper facility for their present condition.

The Psychiatric Intervention Center consists of a screening unit where cases requesting hospitalization are evaluated for such purposes, using a more scientific (DM&S-III) clinical criteria. This has resulted in eliminating those admissions that are not necessary. A psychological intervention unit intervenes in the evaluation of cases that are sent home, the contract home or to the contract hospitals.

The Psychiatric Intervention Center has also been used to evaluate patients presently in contract hospitals. This was recently done at the Los Angeles Contract Hospital. Over a period of time the Medical Center was able to remove all the patients at the Los Angeles facility and either discharge them or admit them to a facility that was more appropriate to the patient's needs.

In the next month or so, VAM&ROC San Juan plans to institute a plan whereby each patient in their contract hospitals will be brought back to the Medical Center for evaluation by the PIC unit.

The Psychiatric Intervention Center has had the following effects:

There has been close to a 20 percent reduction in admissions to the contract hospitals.

Some patients who preferred to go to contract hospitals so that they could remain there for prolonged periods are complaining about being screened at the VA Medical Center where a decision is made about their referral to contract hospitals.

In addition to the above, Dr. M. A. Cardona, Associate Chief of Staff for Ambulatory Care visits each contract hospital on a quarterly basis to review records and treatment files of Veterans Administration patients. This review is done to make sure that the treatment provided is appropriate for the condition for which the patient was admitted.

The San Juan VAM&ROC is presently recruiting a full-time psychiatrist to monitor the care provided much more closely than is now being done at the contract hospitals in San Juan. It is hoped that this physician will become much more involved in the actual care provided each VA patient.

All of the processes mentioned above will not completely eliminate the need for contract beds. The Hato Rey Psychiatric Association is presently constructing a large psychiatric hospital to be opened in early 1985. The Medical Center has plans to transfer all remaining veterans in Hato Rey to this new facility until construction of the new psychiatric beds at San Juan and the remodeling of the old wing is completed.

Question 13. During the staff visit to San Juan, several numbers were mentioned concerning the bed requirement for the hospital. What is the latest bed requirement number?

Answer 13. The bed requirement is 910 beds distributed as follows: 482 in psychiatry, 117 in surgery, 301 in medicine, and 10 in blind rehabilitation.

Congressman Dan Mica to Veterans' Administration

Question 1. It is my understanding that OMB has given the go ahead for the VA to reprogram $3 million of 1984 Advance Planning Funds for the preliminary planning of the Palm Beach VA Hospital. What is the status of the reprogramming proposal?

Answer. 1. It is pending before the Appropriation Committees.

Question 2. According to Veterans Administration staff, my staff has been in contact with, reprogramming procedures are routine for the VA and this proposal should be approved without complications. Can you foresee any problems with this reallocation of funds?

Answer 2. No. Funding is available from the Major Projects Working Reserve.

Question 3. Once the funds are reprogrammed, when can the VA begin using the funds for preliminary planning?

Answer 3. Immediately. The first step is a solicitation for proposals to perform an Environmental Impact Statement. It is ready for issue.

Question 4. With the reprogramming of funds, will the construction schedule for the Palm Beach VA Hospital be accelerated?

Answer 4. The reprogramming action was taken in an attempt to keep the project on a schedule which would permit design funding in fiscal year 1987, construction funding in fiscal year 1988 as shown in the Veterans' Administration 5-Year Needs Assessment.

Prepared Statement of David M. Szumowski, National Secretary of the Blinded Veterans Association

My name is David Szumowski and I am the National Secretary of the Blinded Veterans Association. I am pleased and honored to be here today along with my colleague on the BVA Board of Directors, Mr. Jerry Monroe of Brick Town, N.J., to represent the Blinded Veterans Association at this hearing. We are filling in for Thomas Miller, the BVA's National President. Mr. Miller and several other members of the BVA Board are meeting today with officials of the Veterans Administration about health care and other benefits specifically related to blinded veterans.

The BVA appreciates the opportunity to be here today to discuss the VA's Medical District Initiated Program Planning system, better known as MEDIPP. Although MEDIPP was initiated by the VA in 1981, this new health care planning tool has received much more attention of late, especially from the BVA. The VA has testified on several occasions that the MEDIPP process reverses the trend of highly centralized planning from the VA Central Office and provides more authority in health planning at the local level. This is designed so the VA can plan more effectively for the health care needs of a changing and a dynamic veterans population. This system is designed to identify the health care needs of a veterans population which is shifting geographically and aging at a rate faster than the non-veterans population.

Therefore, MEDIPP is a vital tool for the VA to respond to the increasing demand for health care services likely to result from an aging veterans population. MEDIPP's role in planning for the needs of aging veterans was higlighted in a recent report of the VA's Special Medical Advisory Group Task Force on the VA Geriatric Plan. The report said that VA's "local managers must have sufficient flexibility in planning and initiating geriatric programs" and that MEDIPP is the "effective instrument" for such planning.

Because MEDIPP decentralizes health care planning, local units within the VA will have greater freedom of choice to develop effective models for health care delivery to veterans throughout the remaining years of this century and beyond. The VA's twenty-eight medical districts are the core of MEDIPP. It is the Director of the Medical District who has the responsibility for administering the district MEDIPP plan and determining the role of each medical center in his district in the development of the MEDIPP Plan.

Additionally, the means for consumer involvement—that being representation from veterans organizations—is also determined by the Director of the Medical District. Veterans, themselves, should be involved at each stage of the MEDIPP process.

Nobody can argue against the philosophy of the MEDIPP concept. Planning at the local level tends to be better planning in the sense that health care planners at the medical center and medical district levels—in consultation with veterans who know best their own needs—should have a better understanding of veterans needs and the capacity of existing health care facilities to deliver those services. Such planning also should serve to maximize the limited dollars available for veterans health care both now and in the future. With less money over all being invested by the federal government in health care planning because of hith budget deficits and with increasing medical costs, the MEDIPP process is being watched closely by all those with an interest in our nation's health care agenda; MEDIPP could serve as an example for other agencies involved in health care planning for the non-veterans sector.

The MEDIPP process has the capacity to ensure that the VA is responsive to the specific health care needs of veterans in each district. It does not necessarily estaolish a standard set of objectives for each medical district, but rather MEDIPP provides each medical district with the flexibility to respond to the needs of veterans in a specific geographic jursidiction. However, this also makes VA officials in the medical districts and the medical centers responsible for ensuring the involvement of veterans organizations in the MEDIPP process, especially in the early stages of MEDIPP at the medical center and medical district levels—that is, before the plan has been forwarded to the VA Center Office.

It is this responsibility with which the BVA is most concerned. Recognizing the importance of MEDIPP—both in terms of its overall impact on the VA health care

system as well as its specific impact on the individual lives of veterans—the BVA has been working in recent months to become more intricately involved in the MEDIPP process so that recommendations forwarded to the VA Central Office have reflected consideration of the special needs of blinded veterans. As a result of these efforts, it is clear to the BVA that the MEDIPP process must provide for a more formalized system of input from veterans as consumers at the medical district and medical center levels. More importantly, as far as the BVA is concerned, MEDIPP must open up to blinded veterans.

The BVA corresponded with each of the 28 medical district directors to learn what means of input would be available in each district for blinded veterans. The BVA also recommended to each medical district director the names of individual blinded veterans who could participate in the MEDIPP process in their districts as representatives of blinded veterans. Twenty of the twenty-eight medical districts responded to the BVA's written request. As of this date, eight medical district directors have not yet responded in any form to the BVA's request. However, only four of the twenty medical districts which responded had a structured District Planning Board or Council. Only two of these districts invited the recommended blinded veterans to participate on the panel. The other two replied that they had already made provisions for veterans representation which did not include blinded veterans. Fifteen of the medical districts replied that they did not have a formalized medical district panel. Thirteen of these fifteen replied that the medical centers—not the medical district—had the responsibility to appraise veterans of the progress of the MEDIPP planning process. Two of the medical districts replied that they were uncertain as to how to ensure appropriate veterans' input and were waiting for additional direction from the Central Office. In summary, then, our efforts produced the following result: in only two districts and one medical center were blinded veterans invited to participate in meetings. (See Corresponding Chart on next page.)

CHART OF MEDICAL DISTRICT RESPONSES TO BVA LETTER

REQUESTING INVOLVEMENT IN MEDIPP

Medical District No.	Responded to BVA Request	Did not Respond to BVA Request	Has Organized Regional Planning Council	Has no Medical District Panel	Provides for Involvement at Medical Center Level	Not yet Certain On Means To Involve Veterans	Invited BVA to Meeting
1	X			X	X		
2		X					
3	X			X		X	
4	X			X	X		
5	X			X	X		
6	X			X		X	
7	X			X	X		X
8	X		X				X
9	X						
10		X					X
11		X					
12		X					
13		X					
14		X					
15	X						
16	X		X	X	X		
17	X		X				X
18	X			X	X		
19		X					
20	X						
21		X		X	X		
22	X		X				
23	X						
24	X			X	X		
25	X			X	X		
26	X			X	X		
27	X			X	X		
28	X			X	X		
Totals	20	8	4	15	13	2	3

As consumers, and also as beneficiaries of the VA medical system, the veteran must be involved in each phase of the MEDIPP process. It is not enough to be appraised of the progress of a MEDIPP plan. The veteran must be a participant and share in the responsibilities and the challenges now confronting the VA medical system.

The rhetorical question which rises is this: Which veterans groups should be involved in the process? Obviously, not all veterans organizations have the need or the desire to be involved in MEDIPP. However, there can be no doubt that organizations representing disabled veterans—especially service-connected disabled veterans—have an investment and a stake in the VA health care system. We cannot testify today in favor or against involvement of any specific veterans organization—other than the BVA—in the MEDIPP process. However, we can speak today from OUR experience. Blinded veterans have very special needs. It is important for this committee and the VA to recognize a basic reality about blindness and blind people. This reality was best phrased by Father Thomas Carroll, an expert in blindness and a man whose vision of blindness and the unlimited capacities of blind people helped mold the philosophy of the BVA. It was Father Carroll who said, "Only the blind have an experiential knowledge of blindness and therefore a true realization of its meaning. But, this does not however preclude the possibility that sighted people can be educated so as to gain a true intellectual understanding of blindness and that some can be trained so as to achieve also that empathy which is of such great importance."

This is the role of the BVA in the MEDIPP process. Only the BVA has the experience and the knowledge to represent blinded veterans in this process. Ours is a population that regrettably is likely to increase, not necessarily because of new international conflicts, but from the one fact with which MEDIPP was designed to deal—the aging of the veterans population. The Blinded Veterans Association intends in the next few years to put more emphasis on the specific health care needs of older blinded veterans and older veterans who newly experience blindness or serious visual impairments. We want to help the VA plan both for our futures—that is, for those of us here today—but also for many others who will be relying on us and you to ensure that health care facilities and services are available as needed.

We strongly recommend to this subcommittee that it encourage the VA to provide for more formalized input from veterans, themselves, at each stage of the MEDIPP process and we assure both you and the VA that we will continue to work to attempt to become involved in that process.

Although the BVA has been afforded an opportunity to participate in briefings on MEDIPP at the VA Central Office, MEDIPP plans have not reflected any input from blinded veterans at the grassroots level. Blinded veterans already have indicated a willingness to participate in such efforts at the grassroots levels; now, however, the VA must work to facilitate that cooperation within the MEDIPP bureaucracy.

I would also like today to make some comments about the status of our blinded veterans in Puerto Rico.

The BVA has testified before this subcommittee as well as the full Committee on Veterans Affairs both in the House and the Senate on the need for a blind rehabilitation facility in Puerto Rico. Currently, blinded veterans in Puerto Rico must travel to West Haven, Connecticut to participate in a blind rehabilitation program. The absence of a VA blind rehabilitation facility in Puerto Rico is further aggravated by the lack of any accredited blind rehabilitation facility on the island.

As you might expect, many Puerto Rican blinded veterans are not willing to leave their homes, their families, or their homeland to travel to an area with different weather, language, and culture.

The VA, itself, estimates that there are approximately 600 blinded veterans in Puerto Rico. The need for a blind rehabilitation facility is long overdue.

As this committee knows, we have been working in recent years to persuade the VA to fund such a facility. We are very pleased to know that our efforts have met with success as reflected in the VA's construction budget recently presented by the VA to this committee. Nine million dollars has been proposed to construct a nursing home and a 10 bed blind rehabilitation clinic in San Juan. It is our understanding that this level of funding will be sufficient for construction, but that it will not include any equipment or staffing personnel costs. This is to be included in the VA's budget request for fiscal year 1986 meaning that the clinic will probably not open until sometime after October, 1985—more than two years from now.

Although we are pleased by inclusion of $9 million in the VA's budget for fiscal year 1985, we want to work with the members of this subcommittee and the full committee to open a temporary non-residential day care blind clinic in San Juan. Although such a facility would not be a long term solution to the existing problem,

it would be an appropriate means to respond to existing problems while construction is underway. This also will ensure that the personnel and the equipment are in place so that an operational clinic can open immediately upon completion of construction. In this way, blinded veterans can be assured that the experiences of the Birmingham center opening are not repeated. For those of you unfamiliar with that situation, the center had its formal opening without all the necessary equipment or personnel in place. Consequently, the actual operational opening of the center—that is, when the center could accept a full contingent of students, was delayed for several months. This delay was due to inadequate funding levels. We understand that the space for such a non-residential blind clinic—which would require no additional beds—is available in the VA's San Juan Medical Center. With the support and efforts of this subcommittee, we hope the VA Centeral Office will take some action to open a temporary clinic.

Again, on behalf of the BVA, I want to thank you for the opportunity to be present here today. The BVA will be presenting its legislative program at a combined hearing of the House and Senate Veterans Affairs Committees on March 28. We look forward to being with you again on that day when we will address more fully the special health care needs of the blinded veterans population.

PREPARED STATEMENT OF JOSEPH ZOLDAN, NATIONAL COMMANDER OF JEWISH WAR VETERANS OF THE UNITED STATES OF AMERICA

Mr. Chairman and Members of the Subcommittee:

It is an honor for me to appear before you today on behalf of the Jewish War Veterans of the USA to discuss our views on the VA's Medical Construction Program for fiscal year 1985.

Mr. Chairman, first, I would like to extend my appreciation and thanks to you and the staff of this subcommittee for your hard work and continued commitment to maintaining the well-being of our nation's veterans. Our members of the oldest active war veterans' organization in the USA stand ready to assist you to ensure essential medical care and construction programs are maintained and realistically funded.

We believe our nation has a clear responsibility and commitment to maintain and up-grade the quality of VA medical care systems and to meet the health needs or an ever-aging veterans' population. I come before you today to reaffirm this commitment and express my hope that our country will never forget those men and women who served, and in some cases, given the ultimate sacrifice for our country.

With this background in mind, the specifics of the VA's medical construction budget for fiscal year 1985 represents a mixed bag of hope for the veterans of our country.

There is no doubt that the VA's medical care and construction budget should be given top priority over the next two decades. In this regard, the budget request for fiscal year 1985 is not satisfactory and we feel the VA must reestablish its priorities to ensure the safety, modernization, and construction of sufficient VA facilities. These priorities must reflect the changing demographics of the veteran population.

We wholeheartedly support the proposed increase of $290.7 million to $822 million of budget authority for fiscal year 1985; however, these funding levels are barely adequate for the short term. We feel obligated to bring to your attention why the fiscal year 1985 budget proposal fails to meet the realities and expectations of the veteran community for the long run.

As you know, many facilities of the VA's health care system are deteriorating and becoming increasingly outmoded. Many hospitals were not constructed for the use of modern equipment and therefore, are unable to meet modern standards of health care. Therefore, we commend the VA's proposed $28.6 million replacement for its hospital in Houston, Texas which will incorporate a 120-bed nursing home care unit; the proposed modernization program scheduled for the agency's Allen Park, Michigan medical facility; and the remainder of the replacement and modernization projects in Augusta, Georgia; Mountain Home, Tennessee; and New York, New York.

However, we are most distressed that not a single new VA hospital has been proposed for fiscal year 1985. Furthermore, the administration has failed to reconsider its decision to cancel plans to either renovate or modernize the Baltimore VA Medical Center. The Baltimore VA Medical Center is considered by the VA to be one of the ten medical centers most in need of construction, replacement or major modernization. This year's budget has also failed to propose building or modernizing a single facility in Florida despite recent demographic studies indicating that Flor-

ida's veteran population is expanding faster than in any region in the United States.

In the area of nursing home care, we feel this budget's request is inadequate to keep up with the continued expansion of veterans needs. In fiscal year 1984 the VA requested 67.3 million for nursing home care which included the addition of 840 nursing home beds. The budget for fiscal year 1985 is $16.5 million lower, requesting only 50.8 million and an addition of only 57 nursing home beds over last year's request.

Furthermore, the budget for fiscal year 1984 marked the third year in a row in which funds were not authorized for construction of new domiciliary facilities or remodeling existing ones. The VA's medical construction budget for fiscal year 1985 has barely addressed this most serious problem. In fact, the VA has chosen to renovate just one domiciliary facility. Many of these buildings are over 50 years old and do not meet current standards of fire safety. We believe the number of aging veterans, particularly those with insufficient social or family resources to meet minimal care needs, will increase over the next twenty years. We urge this subcommittee to closely monitor this situation and to consider providing additional funds for domiciliary care in the medical construction budget for fiscal year 1985. There is no doubt that inaction will only magnify and increase the cost to be paid by our veterans and the American taxpayer.

All of these budgetary deficiencies will be magnified by current demographic trends in the veteran community. Veterans 65 years or older numbered 3.3 million in 1981; by the year 2000 this figure will triple. In 1981 25 percent of veterans 65 years or older used VA medical services; there is no reason to believe this percentage will change, yet using this percentage as a basis, the 798,000 over 65 veterans who used VA health care services will increase to 2.2 million by the year 2000. Also, our country has a substantial number of women veterans 65 years or older and by the year 2000 they will number 400,000. Furthemore, as documented by the VA, the median age for male veterans is 51.4 years and 51.9 years for female veterans. This subcommittee and our nation's veteran organizations must respond to the realities of our time. Failure to resolve this dilemma, between a lack of budgetary planning by the VA and the Federal Government and increased health demands of veterans, can only result in budgets that do not reflect or answer the growing concerns and needs of veterans across this country.

Finally, the last point to be made about this budget is more of an administrative problem than a budgetary deficiency. Last fall on September 27, 1983, the House Subcommittee on Oversight and Investigations of the Committee on Veteran Affairs investigated allegations made by the Association of Orthopaeddic Chairmen on the status of VA health care. In our opinion, the findings of this report illustrates dangerous trends in VA medical care.

In its summarized form, the major thrust of this report is that Orthopaedic care is in a perilous condition due to improper use of funds, unsafe operating conditions due to old or poorly maintained instruments and to general mismanagement. For example, this report alleged that items such as lawn sprinklers, earthquake proofing, and similar items are often given priority over purchasing artificial hips, surgical instruments and prescription drugs. Also, the length of VA patients' hospitalization is often determined by administrative and budgetary decisions instead of good medical practice. Essentially, patients not only receive inferior care while in-patients, but inferior care as out-patients due to their excessive number which far outstrip the hospitals' ability to care for them.

Finally, surgical and other medical procedures are not scheduled appropriately due to lack of support staff. The report claims that employment contract provisions forced on the VA by labor organizations or voluntarily adopted by VA management do not permit full use of hospital facilities. Mr. Chairman, even if this report is only partially accurate, the seriousness of its charges must be considered. It is important to authorize and appropriate necessary monies for construction of health facilities; however, it is equally important to effectively administer health facilities already built. I urge this Subcommittee to once again monitor this situation and all similar reports so that an accurate picture of VA medical care is obtained.

To conclude, the JWV of the USA views this years medical and construction budget as being barely adequate for the short run. It certainly does not address many of the long term health care problems anticipated from our aging Veteran population. While the VA has never been expected to care for all veterans it must plan for the health needs of the service connected, disabled and needy veterans who are growing older.

Mr. Chairman, thank you for giving us this time to express our views on these important matters.

PREPARED STATEMENT OF JAMES N. MAGILL, SPECIAL ASSISTANT, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. Chairman and members of the subcommittee: Thank you for the opportunity to present the views of the Veterans of Foreign Wars of the United States with respect to the construction program for the Veterans' Administration's Department of Medicine and Surgery. The VFW is appreciative of the Chairman for holding this hearing, demonstrating his and the Subcommittee's continuing concern for the current and future health care needs of our nation's veterans. We would also like to take this opportunity to commend this Subcommittee for its efforts in advancing into law the "Veterans' Health Care Amendment of 1983" (PL 98-160). This measure expands, extends, and improves many beneficial and needed veteran programs.

The VFW, Mr. Chairman, is generally pleased with the $822 million VA medical construction budget for fiscal year 1985. We believe the increase of $291 million over the fiscal year 1984 medical construction budget is urgently needed and deserved. With funding included for replacement/modernization of the medical centers at Allentown Park, Michigan; Augusta, Georgia; Houston, Texas; Mountain Home, Tennessee; and New York, New York, the VA is headed in the right direction to modernize its physical capabilities to meet the growing demand of veterans for health care.

Because of the increasing average age of veterans, the VFW is pleased that $50.8 million is included for the design and construction of seven nursing home care units located in Alexandria, Louisiana; Durham, North Carolina; Murfreesboro, Tennessee; Prescott, Arizona; Providence, Rhode Island; San Juan, Puerto Rico; and West Los Angeles, California. The Durham, North Carolina nursing home is scheduled to include a Geriatric Research and Clinical Center (GRECC). We applaud this action but wish to note the current number of GRECC's still falls short of the 15 authorized by Public Law 96-330. We believe the GRECC program gives much needed visibility and respectability to geriatrics and will serve to encourage medical practitioners to advance this emerging medical specialty. Further evidence of the growing concern for our elderly veterans is demonstrated in the increase from $18 million to $35 million in the grant program for the construction of state extended care facilities. These facilities play a vital role in the care of the aging veteran and this increase will certainly help reduce the backlog of requests for such grants; thus reducing the demands on similar facilities within the VA.

Moreover, Mr. Chairman, with respect to medical construction, we would be remiss if we did not voice our concern and dismay over the lack of funding for the replacement medical center in the Baltimore-Metropolitan area and the clinical improvements and additions to the Philadelphia, Pennsylvania facility.

The current Five-Year Medical Facility Construction Plan lists the Baltimore project as one of the medical centers most in need of construction, replacement, or major modernization. In 1976, President Ford announced that a 400-bed hospital would be constructed in Baltimore. Funds were appropriated in fiscal year 1977 and to date the VA has spent approximately $8 million on this particular project. Now, according to the VA, the project has been canceled due to budgetary constraints! Undoubetdly, because of the undeniable need in this area, some form of replacement/modernization will have to be undertaken in the future. To modernize an existing facility after spending $8 million on design and the purchase of a construction site, would seem to be an unjustified waste of money. Likewise funding for the Philadelphia, Pennsylvania VA medical center has not been included in the fiscal year 1985 budget. Again, the project has continually been put on the "back burner" with the total estimated cost increasing with each delay. As with Baltimore, the Philadelphia project is totally justified and needed. The conditions under which the Philadelphia VAMC staff and patients provide and receive treatment are distressing. The recognized need for improvement and expansion of the medical center is such that the city of Philadelphia has recently offered to donate land for the projects; provided funding and construction are "begun" by the end of 1986. It is our understanding that some confusion exists as to whether the total construction project must be started or whether a part of it could now be undertaken to safeguard the availability of the donated land. It would certainly be tragic to lose the land in question because of a misunderstanding; or worse, myopia.

Finally Mr. Chairman, we wholeheartedly endorse the concept of the Medical District Initiated Program Planning (MEDIPP) program but, of course, reserve the right to oppose various recommendations should it be warranted. We did have reservations with the first cycle in that we believe the input from medical schools left much to be desired. However, the second cycle, it appears, is showing improvement with increased communication and participation from this community.

Mr. Chairman, inasmuch as the VA's report containing the plans of the Administrator to meet the health care needs of veterans in Puerto Rico and the Virgin Islands in not yet available, we can only make a brief statement on this issue. In recently contacting our representatives in Puerto Rico, we can safely say the situation has not improved with the major concern still being the lack of care for non-service connected veterans. We note that the budget for fiscal year 1985 contains funding for a 120 bed nursing home care unit in Puerto Rico; yet no funding is provided for the resolution of the very real problems of currently supplying psychiatric care to veterans through contract nor for the care of the non-service connected veteran.

Mr. Chairman, appended to my statement are a number of resolutions, adopted at our most recent National Convention addressing issues pertinent to this hearing. They are: Resolution No. 607 entitled "Geriatric and Extended Care"; Resolution No. 634 entitled "Replacement of Veterans Administration Medical Center"; Resolution No. 776 entitled "Matching-Fund Construction Grants to States"; and Resolution No. 777 entitled "Improved Health Care and Facilities For Veterans".

This concludes my statement. I will be happy to respond to any questions you may have.

RESOLUTION NO. 607—GERIATRIC AND EXTENDED CARE

Whereas, in 1980, the Congress authorized the establishment of fifteen Veterans Administration health care facilities as centers of geriatric research, education and clinical activities (GRECC); and

Whereas, it is recognized that current VA extended care capability cannot meet present demands of the eligible aging veteran; and

Whereas, VA medical district planning studies reveal an awareness of that deficiency and have indicated the need to expand long term care capability incrementally through 1990; and

Whereas, the Congress must be receptive to the budget planning process necessary to accomplish this recognized need without sacrificing the level and quality of acute health care for veterans; now, therefore

Be it resolved, by the 84th National Convention of the Veterans of Foreign Wars of the United States, that the Veterans Administration's comprehensive plan to expand geriatric and extended care capability for the aging veteran be approved and funded.

[Adopted by the 84th National Convention of the Veterans of Foreign Wars of the United States held in New Orleans, Louisiana, August 12-19, 1983.—Resolution No. 607]

RESOLUTION NO. 634—REPLACEMENT OF VETERANS ADMINISTRATION MEDICAL CENTER, ALLEN PARK, MICH.

Whereas, for the past sixteen years, the Department of Michigan, Veterans of Foreign Wars of the United States, has made attempts to have the Veterans Administration Medical Center, Allen Park, Michigan, replaced with a new facility; and

Whereas, Veterans of Foreign Wars' hospital surveys conducted in February, 1975 and again in February, 1978, revealed findings that justified an early replacement of the Allen Park facility and further, the VFW conclusions were confirmed by a special study (identified as the Rossetti Report) which was conducted on orders from the Congress of the United States, and the hospital should be replaced; and

Whereas, in compliance with Public law 96-22, Section 5007, the Veterans Administration has announced a list of ten hospitals most in need of construction, replacement or major modernization, and Allen Park is ranked number six; and

Whereas, in response, the VA is now engaged in a comprehensive study of the facility, but it is fearful that an effort will be made to modernize this situation to save construction dollars over the next five years without regard for the fact that the Allen Park Hospital has built-in deficiencies that cannot be corrected; and

Whereas, over a period of time from a cost effectiveness aspect, it would cost the VA more to operate this hospital than it would to build a new medical center adjacent to Wayne State School of Medicine; now, therefore

Be it resolved, by the 84th National Convention of the Veterans of Foreign Wars of the United States, that the Administrator of Veterans Affairs be urged to seek funds for the replacement of the Allen Park Veterans Administration Medical Center to be constructed adjacent to the Wayne State School of Medicine, Detroit, Michigan; and

Be it further resolved, that the Allen Park Veterans Administration Medical Center not be closed after the new hospital becomes operational but be used for treatment of psychiatric disorders, intermediate care, nursing care patients, and domiciliary care.

[Adopted by the 84th National Convention of the Veterans of Foreign Wars of the United States held in New Orleans, Louisiana, August 12-19, 1983.—Resolution No. 634]

RESOLUTION NO. 776.—MATCHING-FUND CONSTRUCTION GRANTS TO STATES

Whereas, Public Law 97-251, Section 8, extended the program of grants to state home facilities through fiscal year 1986; and

Whereas, the fiscal year 1983 appropriation for this program is $18 million and the 1984 appropriation will be at the same level; and

Whereas, requests for mathcing-fund construction grants to states is in excess of $88 million, or more than five times the current authorization; and

Whereas, future for this program is dependent upon the overall level of funding available to medical care programs of the Veterans Administration and to consideration of the various priorities for the use of those funds; and

Whereas, there is a demonstrated and known shortage of nursing care type beds at existing VA facilities; and

Whereas, an increasing number of World War II veterans are 65 years of age and older, dramatically increasing the number of veterans needing nursing home care or extended medical care; and

Whereas, the Veterans Administration projects the number of veterans over age 65 will more than double in the next ten years, there will be an ever increasing number of older veterans seeking the assistance offered by state veterans' homes; and

Whereas, the 47 state veterans' homes in 33 states and the District of Columbia now provide approximately 17,000 beds for the care and treatment of elderly and/or disabled veterans; and

Whereas, most planning for modernization and/or expansion is predicated on the availability of matching funds through the Veterans Administration; now, therefore

Be it resolved, by the 84th National Convention of the Veterans of Foreign Wars of the United States, that we support increasing the present $18,000,000 matching-fund for the construction and remodeling of state veterans' homes, hospital, nursing and domiciliary facilities to at least $25,000,000 per annum, for no less than the next five years.

[Adopted by the 84th National Convention of the Veterans of Foreign Wars of the United States held in New Orleans, Louisiana, August 12-19, 1983.—Resolution No. 776]

RESOLUTION NO. 777.—IMPROVED HEALTH CARE AND FACILITIES FOR VETERANS OF PUERTO RICO AND VIRGIN ISLANDS

Whereas, the VA health care facilities in Puerto Rico and the Virgin Islands are inadequate to meet the needs of veterans in that Commonwealth; and

Whereas, the present unsatisfactory contracting arrangements with the private sector is not cost effective nor does it provide the level or quality of care consistent with the standards of the Veterans Administration; and

Whereas, as a consequence of these inadequacies the Congress directed the VA to prepare studies on the health care needs of veterans in Puerto Rico and the Virgin Islands; and

Whereas, the final study required the transmission of a "specific detailed proposal including any construction project that the VA considered necessary, pertaining to health care for eligible veterans in Puerto Rico and the Virgin Islands and most particularly, for meeting the health care needs of those veterans included in that population who have service connected disabilities;" and

Whereas, this report was requested in order that a permanent solution could be developed to provide appropriate and cost effective health care to veterans residing on outlying locations; and in the event new construction was involved the Congress requested the VA to prepare the needed project(s) for inclusion in the President's budget; and

Whereas, the finalized report substantiated arguments for positive action to alleviate the very undesirable situation existing in Puerto Rico; now, therefore

Be it resolved, by the 84th National Convention of the Veterans of Foreign Wars of the United States, that Congress authorize projects for modernization and new construction additions in Puerto Rico and the Virgin Islands that will provide all inpatient needs, including those which are currently met through the contract program; and

Be it further resolved, that the VA Medical Center Outpatient Clinic be expanded to meet the demands for outpatient treatment, that the Ponce Outpatient Clinic be VA operated and new Outpatient Clinic be constructed in Mayaguez, and

Be it further resolved, that a 120 bed Nursing Home Care Unit be constructed in San Juan; and

Be it further resolved, that Congress should amend Section 601 (4)(C)(v) of Title 38 U.S. Code, to extend the existing contract authority of that provision until September 30, 1986, in order for the VA to provide continued health care during the budget and construction process.

[Adopted by the 84th National Convention of the Veterans of Foreign Wars of the United States held in New Orleans, Louisiana, August 12-19, 1983.—Resolution No. 777]

PREPARED STATEMENT OF PAUL S. EGAN, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE COMMISSION AND ROBERT E. LYNGH, DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. Chairman and Members of the Subcommittee: The American Legion is pleased to have this opportunity to present its views on the subject of construction planned for the Veterans Administration Medical Program for Fiscal Year 1985, and on provision of health care services to the veterans of Puerto Rico and the Virgin Islands.

There is no need for us to discuss with the Subcommittee the details of the VA's Budget Request for medical construction for fiscal year 1985, since, obviously, you have all that information before you. What we would like to do is to briefly state to you the American Legion's perspective on the VA's renovation and replacement program.

First we should say we are in fact pleased and appreciative of the Budget request for fiscal year 1985 of $760 million for construcion in the medical program. We have reviewed the line item proposals for the use of these funds, and we have no hesitation in saying they all appear necessary and justified to us, and we hope the Committee will recommend their authorization.

For many years The American Legion has been intensely interested in the VA's renovation and replacement program. We believe we have developed a reasonably accurate and detailed file of information on what is needed. We do this through the site visits of our Field Representatives. Our six Field Representatives complete more than 65 site visits each year to VA installations. Their site visit reports, which are shared with the House Committee, include detailed information on the condition of the physical plant of VA Medical Centers, Clinics, Nursing Homes and Domiciliaries. They obtain information on the Five Year Plan for each facility and report on their view of that insofar as needed physical improvements are concerned.

Two years ago, when the previous Administrator appointed a special committee to survey and report on the medical construction program, The American Legion was the only organization that could produce up-to-date information on the subject, drawn from our site visit reports. We hared that information with the Special Committee.

The information we have accumulated, and our long-standing interest in the VA's health care program for veterans have, we believe, given us a good perspective on what is being done, what needs to be done, and what hasn't been done in recent years to maintain the physical plant of the system.

Our perspective is projected from our complete dedication to the maintenance of the present VA health care program for veterans, and our conviction that the physical plant of that program represents a multi-billion dollar capital investment by the Federal Government in the largest and most comprehensive health care system in the United States. This system, including its physical plant, represents in fact an invaluable national resource that helps, not only veterans, but through its education and research elements, the entire American people. It can be said that if the present system were for any reason lost or discontinued it would be, in fact, irreplaceable.

Once past that point, the next observation that must be made is that the present physical plant is a deteriorating one. And that is true for a number of reasons. The foremost reason is that the plant was neglected for a considerable number of years. Some years ago, Congress, foresightedly developed a ten year program to renovate and update the system, and went so far as to set a schedule of fund appropriations designed to keep the plan on course. However, regrettable, and as so often happens in the complicated business of government, the plan was never executed as had been intended. The system, instead when through a period of relative neglect, during which more needs developed and construction costs soared. Ultimately, Congress and the Executive Branch again addressed the problem, only to find that the needs had grown tremendously and the costs had escalated. Those facts have indeed

led to the need for the kind of Budget recommendations we have today, of some $760 million in construction funding for fiscal year 1985.

The other thing that has occurred during these intervening years is that the medical technology has far surpassed the ability of available facilities to meet its need. For example, there are in the system today, hospitals and other buildings being used for patient care that were built before WW II. Most of the remainder of the facilities were built during the years immediately following WW II. Today they are simply not configured for the practice of 1984 quality medicine. These facilities were all built before intensive care units were developed. Yet you cannot operate a hospital today without such units. Fire, safety and privacy requirements have gone through major changes in recent years, requiring reconfiguration of wards, clinics and supporting features of all medical facilities. Introduction of modern equipment and therapeutic methodologies have changed all space requirements in the hospitals, and the size of wards and numbers of beds that can be maintained. Some of the oldest of the buildings still in use are simply worn out and need to be torn down and replaced. The Subcommittee is as much aware of these things as are we. All of these factors together have created an ongoing need for a constant infusion of funds to renovate and replace facilities system-wide. Our site visits establish the fact that much has been accomplished in recent years, and much more is currently under way. The system is in fact being upgraded—a fact for which both Congress and the Executive Branch—in succeeding Administrations—deserve much credit. What is needed now is a continuation of the momentum that has been built up, so it will be maintained until the task is, in the main, fully accomplished. As we stated earlier, we realize the cost for all this is going to be high. But at the same time it must be remembered that what we have here is not just an expenditure of funds. This is a capital investment by the Federal Government in an invaluable national resource; a resource that will serve all of the American people long into the next century. That certainly is not a bad way for Congress to spend the people's money.

With that perspective, and having stated our approval of the Administration's funds requests for fiscal year 1985, we wish to speak to the Subcommittee about certain shortfalls we have identified in the proposed Budget. We refer specifically to the replacement hospital for Baltimore and the clinical addition and nursing home care unit for VAMC Philadelphia.

The need for the replacement hospital at Baltimore is clear for all to see. All anyone has to do is walk through the present Baltimore facilities at Lock Raven and Fort Howard, and nothing more would need to be said. The need was established; design and planning were completed, funds were appropriated, contracts let, and construction was in fact begun. Then, to our astonishment and dismay, the funds for Baltimore were listed in a rescission message from the President, and suddenly the replacement hospital for Baltimore was cancelled.

We must say this action was a serious mistake that never should have happened. Nothing has changed. The need is still there, as are the veterans who need care. The hospital needs to be built and should be built. Our petition to the Subcommittee is that its authorization be renewed and that construction go forward. That is the only way to recover the money that has already been spent on this project. The American Legion strongly recommends that the Baltimore replacement hospital be constructed.

Then there is the matter of the additions and modifications for the Philadelphia VAMC. These too are badly needed. As we stated to the full Committee on February 8, the Philadelphia VAMC is a tertiary care facility serving a high density population of veterans under extremely difficult conditions. The VAMC is affiliated with two fine medical schools in the University of Pennsylvania and the Thomas Jefferson Medical School. Some very fine medicine is being practiced there to the advantage of the veterans in the area. The facilities are woefully inadequate. The Outpatient Clinic in downtown Philadelphia is a disgrace to the VA and the veterans being served. The General Services Administration is probably the worst landlord in the nation. What is desperately needed at Philadelphia is completion of the clinical addition, the nursing home care unit, and parking facilities. Adding urgency to the situation is the land that has conditionally been donated by the City. As we understand the proviso to the gift, construction must be under way by the end of 1986, or the land will revert to the City. Without the land the improvements will be impossible of accomplishment. Yet, in the face of these facts, the project for Philadelphia has been cycled forward by the Administration to a future year. If that decision is allowed to stand, the situation of Philadelphia will become hopeless. The only solution we see is for the House Committee to recommend authorization for fiscal year 1985, and for funds to be appropriated in such a way that construction will in fact, at least be underway before the end of 1986. The simple fact is there is no need for

this problem to exist. All that is needed is a little foresight by those responsbile, and what is needed at Philadelphia can be accomplished, to the advantage of the Federal Government, and the veterans to be served.

Before we move on to some observations about the Puerto Rico situation we wish to say a word about MEDIPP—the Medical District Initiated Planning process.

MEDIPP is now, we believe, into its third cycle in the VA's Department of Medicine and Surgery. The concept as we understand it is to begin the identification and development of needs at the Medical District level, and to formulate plans to meet the needs on a District-wide basis rather than on a station by station basis. This concept is intended to make DM&S planning more comprehensive, move attuned to the needs of the veteran population to be served, and more efficient and cost-effective for the Government. The American Legion certainly has no problem with this concept. It makes a lot of sense to us. One thing we do know about the planning process that could and did result in failure to identify needs in proper fashion, and there were in fact some instances where needs changed and the VA planning process did not have a mechanism to respond to such changes, with resulting modifications in the plan. This could lead to expenditure of funds in a way that was not to the best interests of the Government, or of the veteran. It would appear to us that MEDIPP, properly organized and pursued, should eliminate the faults and assure that the planning process does indeed identify and respond to changing needs of the system and of the veterans to be served.

There has been consumer representation in most of the MEDIPP activity at the District level. In those instances where the service organizations were not involved, we believe corrective action has been taken. We of the Legion believe that in the main we have been kept abreast of what is going on with MEDIPP, and that the VA officers have given consideration to our input.

It would be our recommendation that the MEDIPP process should be continued, until more time has passed and there has been opportunity to determine whether it in fact does what it is intended to do.

As to whether the Budget requests for fiscal year 1985 reflect MEDIPP recommendations, we cannot answer that, we presume the information will be provided by VA representatives.

We would like to proceed now to some observations on the subject of delivery of health care services to the veterans of Puerto Rico and the Virgin Islands.

We can first dispose of the Virgin Islands by saying that as far as we know, the contract authority Congress has granted to VA for the Virgin Islands is working satisfactorily in assuring care as needed to veterans. We believe certain types of cases are Medevaced to San Juan.

We have been advised by VA that authority has now been given to establish a Veterans Outreach Center at St. Croix, which has a veteran population approximating 2,500, without easy access to counselling and other services. The Legion encourages VA to proceed with this addition.

The situation regarding delivery of health services to the veteran population on the island of Puerto Rico is a complex and difficult one. The American Legion, while crediting and commending VA for what has been done so far to provide for Puerto Rican veterans, still believes some further actions are required in addition to what is being done and planned.

The dominating factors from which all observations about Puerto Rico must be projected are the size of the veteran population, its economic condition, and the distance of the island from the mainland of the United States. A further factor is that the needs of Puerto Rico must be conveyed to the Congress by a Delegate who has no vote, and thus the representation of the citizenry is extremely limited.

An American Legion representative visited Puerto Rico on two occasions during 1983, and in doing so gained a fairly comprehensive understanding of the conditions that prevail there and impact on delivery of benefits by VA.

The first visit resulted in a detailed communication to the Chief Medical Director, dated April 29, 1983. In preparation of this statement the earlier document has been reviewed, and it is believed to continue to be valid in all respects. A copy is attached to this statement and is commended to the attention of the Subcommittee.

A comprehension of the atmosphere in which employees at the VAMC do their work cannot be conveyed in words, and in our judgment can only be grasped through a visit to the installation.

The hospital and its clinics are crowded all the time. The hospital maintains an Average Daily Patient Census of almost 90 percent—certainly one of the highest in the system, for a tertiary care GM&S facility.

VAMC San Juan practices the most sophisticated medicine in the Caribbean Basin. It is visited by teams from other Caribbean nations seeking to learn the latest treatment modalities that are found there.

Equipment, as it appeared to us, is up to date and contributes to the VAMC being one of the most progressive in the system. The problem, as we see it, is not so much equipment as it is personnel.

The VAMC has one of the lowest staff to patient ratios in the VA system. Service after service told our representative they were overwhelmed with work and had barely enough personnel to care for their clientele. The attached report includes details in that regard.

In considering VAMC San Juan, it must be borne in mind that community facilities in the Commonwealth are very limited, and as a result all public authorities have adopted a simple proposition: that all veterans are the total responsibility of the VA, including nonservice-connected and emergency cases.

Thus, for example, while the designers of the present facility did not have the foresight to include an Emergency Clinic in the design, the hospital is constantly required to provide emergency services to veterans, and has had to use otherwise needed space for the Emergency Clinic. There still seems to be no realization of that fact at Central Office.

When elderly veterans, albeit nonservice-connected, but with VA the only public health care available to them, have to wait 6 months for an appointment in the urology and gastrointestinal clinics, 90 days for radiology service, 11 weeks for barium enemas, that cannot be considered an optimum modus operandi.

The shortage of Registered Nurses, with so many seriously ill patients, increases the danger of burnout. Only dedication to the mission keeps many of these and other health care professionals at their work. Admittedly, the unfavorable economic climate in Puerto Rico militates in the direction of reducing staff turnover, but the economic climate that favors VA employment is offset by the overwork and job pressures that can become almost unbearable in a hospital that is constantly dealing with large numbers of seriously ill patients.

The Legion notes with approval the fiscal year 1985 Budget request includes $9 million for the nursing home care unit and the Blind Rehabilitation Unit at San Juan. Our guess is that the new nursing home unit will probably fill up immediately with patients and there will still be need for the contract beds now used at the Fernandez Garcia Clinic, which houses medically infirm, and mostly aged patients.

The prompt establishment of a satellite clinic at Ponce, may make it possible to terminate the contracts with the private hospitals at Ponce, and thus may be cost-effective as well as providing better service. The excellent situation prevailing at the Mayaguez Clinic certainly gives hope for this result.

It would seem the bottom line of this presentation, in addition to the observations in the attached report is that what is really needed at VAMC San Juan is a greater allocation of funds, permitting, mainly an increase in the number of health professionals to care for the very heavy case load that follows the population and economic climate in Puerto Rico. The American Legion has so stated to VA. The response receive is the same as that received every time we submit similar recommendations about any other VAMC, which essentially amounts to: the need is recognized, but must be viewed in context with other system-wide priorities. We know all about system-wide priorities. Through our Field Service we visit more than 65 VAMC's each year—and all of them have their share of problems.

We do believe, however, that some special consideration should really be given to Puerto Rico for the reasons stated in our letter to the Chief Medical Director, of last April. The veteran population on Puerto Rico is large; the economic situation is difficult; community facilities are not available; mental health problems are epidemic; the veteran population is aging and thus developing more health problems; the distance factor from the mainland makes it more difficult for both patients and staff to avail themselves of all of the treatment modalities the VA system now has; and the United States does, in fact have a special obligation to the citizens of the Commonwealth who, though not from one of the United States, have served willingly and faithfully in its Armed Forces.

We hope the Subcommittee will be able to give some special consideration to the problems and the needs of the veterans of Puerto Rico.

Once more we thank the Subcommittee for the opportunity to present our views at this time.

THE AMERICAN LEGION,
Washington, D.C., April 29, 1983.

Dr. DONALD L. CUSTIS,
Chief Medical Director, Veterans Administration, Washington, D.C.

DEAR DR. CUSTIS. During the period April 18-20 I had opportunity to visit VAMC San Juan, Puerto Rico. I wish to share with you my observations and conclusions, derived from that visit. Included with these remarks are some specific recommendations relating to matters that I believe should be addressed promptly by the Department of Medicine and Surgery.

To preface what follows it is necessary to place in perspective the situation of the VAMC San Juan. This facility serves a veteran population on an island that lies 1,000 miles off the shores of the United States. By reason of that fact Puerto Rico veterans have special problems in receiving the attention to their needs that is routinely provided by VA to veterans in the United States. This has resulted in certain inequities in the provision of benefits under the VA's health care program. There is a special and essential unfairness to this because Puerto Rico veterans, although living on an island that is a possession of the United States, and having United States citizenship, with its concomitant responsibility to provide military service, do not have full representation in Congress, or in the councils of the Federal Government, and as a result do not in fact receive the same attention to their needs that is given to other American war veterans.

In the judgment of the American Legion, the situation described above creates a responsibility and obligation on the VA to pay special attention to these veterans, and to see to their needs in a special way.

It is acknowledged that much is being done for Puerto Rico veterans, and special provisions are made for them. However, it is also true that in recent years there has been a lack of attention by VA, and by Congress (and as a matter of fact, by The American Legion also), with a resulting development of problems that need to be addressed promptly at this juncture.

It is hoped that what follows in this letter will be reviewed in the context of the remarks set forth above herein.

First, there is the matter of the size of the Puerto Rico veteran population. The 1980 Decennial Census apparently estimates a Puerto Rico veteran population of 130,000, and the Task Force Report issued by VA and dated January 1983 uses this figure in its projections. All authorities on the island agree the figure of 130,000 is low, probably by half. There is probably a veteran population of at least 260,000 in Puerto Rico.

The reason for the discrepancy is the reluctance of most Puerto Ricans to complete government questionnaires. This reluctance results in an underestimation of the population of the island, and of the veteran population with its dependents.

All considerations of problems affecting VAMC San Juan must be in perspective of a Bed Occupancy Rate that approximates a steady 90 percent—almost saturation point.

The next factor that impacts on provision of care to Puerto Rican veterans is that the Commonwealth is woefully short of community resources in all aspects of health care. What meager resources are available routinely decline to accept veterans, operating on the fixed conclusion that veterans are the responsibility of VA. Thus, when VA refuses care to a veteran that veteran usually gets no care at all. A distressing situation.

VA has issued a report entitled A Plan For The Delivery of Health Care To Veterans In Puerto Rico And The Virgin Islands. The Report is dated January, 1983. VAMC authorities indicated to me their acceptance of the Report as an essentially fair evaluation of the situation, and stated that the full implementation of the Report's recommendations would do much to alleviate the current problems affecting care of veterans. My own feeling is that the problems are so acute that an effort should be made to advance the timetable for implementation of the Report's recommendations. I realize that time frames for action by a government agency are always extended. However, in view of the years that have been allowed to pass while the problems in Puerto Rico developed and expanded, I believe a special effort is in order by VA to address the problems there, and to seek whatever funding is necessary from Congress. The American Legion will support any effort tc secure funding in an early fiscal year to commence the changes necessary.

VAMC San Juan is presently incorporated in Medical District 3, along with 8 other VAMC's in New York and Connecticut. I was told, and I believe this assignment is not working well. Because of its geographical separation VAMC San Juan does not receive a full measure of consideration in the formulation and execution of plans affecting the Medical District. This is especially true, I am told, with reference

to fund allocations. It is my opinion that VAMC San Juan, which is located on an island 1,000 miles off the coast of the U.S., should be formed into a Medical District of its own. I believe this would more appropriately assure the veterans of Puerto Rico that DM&S would pay direct attention to their needs and entitlements in the field of health care.

The core staff ratio at VAMC San Juan is currently 1.48. This is far too low for a tertiary care hospital, and is not in balance with core staff rations in other tertiary care hospitals, or in Medical District 3. The only core staff ratio in Medical District 3, lower than San Juan is Montrose. I also checked 9 other VAMC's at random, and found only two of the 9 with lower core staff ratios. DM&S should take action promptly to redress the balance and to assign a more appropriate core staff ratio to San Juan, given the highly sophisticated quality of medicine being practiced at that facility.

The staff at VAMC San Juan believes it pays a price for being located on an island off the shores of the U.S., resulting in the facility receiving less than it needs and is entitled to have in the way of attention to its problems by Central Office DM&S. A special effort should be made by DM&S to remedy this situation. The veterans of Puerto Rico are aware of this situation and it is one of the factors leading these veterans to believe they are neglected by VA. This information comes to me from the leadership of The American Legion of Puerto Rico—the largest group of organized veterans on the island.

Neither the present Chief Medical Director nor the Deputy Chief Medical Director has yet made a full-fledged inspection trip to Puerto Rico. One of these officers should make such an inspection trip, of both VA and all contract facilities on the island as soon as possible.

Medical Administration Service is in critical condition. It now operates with 2 patient services units, whereas it needs at least 5 units. With a present FTE of 185, the Service is short a minimum of 107 FTE's. Among the results of this condition are the facts that many patient summaries must be handwritten (an inappropriate waste of physicians' time) due to overload in the typing pool; compensation and pension exams do not begin to meet DM&S standards, resulting in long delays in rating cases; fee basis payments are a minimum of three months' behind, leading to the jeopardizing of fee basis outlets for service-connected cases.

Nursing Service is perilously thin in supply of RN's. A minimum of 114 additional RN's are needed to insure complete nursing coverage of all activities on all shifts.

Spinal Cord Injury Service. This 20 bed unit has a staff ratio of 1.6, which should be at least 2 to 1. A survey, if one were taken might show San Juan SCI to have the lowest staff ratio among all SCI units in the system.

This unit has another complaint. I was told that through the years San Juan SCI has led the system in SCI sports programs. Yet when Central Office DM&S began to organize centrally sponsored SCI sports programs—San Juan was ignored. This leads to paranoia by patients and staff.

It should be noted at this juncture in this recitation that the San Juan facility was not optimally designed to meet local needs. E.G., no Emergency Room was included. Shortly following activation, an Emergency Room had to be created—thus using up space needed for other purposes. Now an effort is being made to curtail emergency services at the VAMC. The American Legion categorically opposes this effort for the following reasons.

First, it is not possible to operate a tertiary care hospital without an emergency capability. The very nature of a hospital requires it. Second, it must be borne in mind that community resources are extremely limited in San Juan, unlike conditions in urban settings on the mainland. In San Juan, patients identified as veterans are automatically taken to VAMC—and if rejected there, there is often simply no other place for them to go. Most private hospitals in San Juan are proprietary. Most Puerto Rican veterans are poor. Ergo, proprietary hospitals will not accept veterans, even in an emergency condition.

The Emergency Room capability at San Juan should be maintained in full.

Neuropsychiatric Service carries perhaps the single heaviest work load of any service. More than 90 percent of cases are service-connected. Mental Health problems are extremely serious among the Puerto Rican people, and this is reflected in the veteran population. To carry this heavy work load the service is seriously short-staffed. A minimum of 11 FTE's are immediately needed to enable the service to cope with the demand for service—by service-connected veterans.

Outpatient Clinics are overloaded. Veterans begin arriving sometimes as early as three o'clock in the morning to take their place in line for care. All cases are service-connected. Examples of overload: appointments for urology and gastrointestinal clinics require a minimum of 6 months' waiting period. This cannot be considered

satisfactory care for service/connected veterans. Central Office DM&S should conduct a survey of the Clinics and take whatever action is necessary with regard to space and staff to improve this situation.

Radiology Service maintains a 90 day backlog. Barium enemas are scheduled 11 weeks in advance. Five additional MDs are immediately needed to cope with the work load. Three FTE's have been allocated by CO for the incoming CT Scanner, but no MD. This will result in further backlogging. Something should definitely be done about the Radiology Service.

Laboratory Service needs an additional 10 FTE's to cope with work load. Prompt lab service is an obvious need in a tertiary care hospital. Presently lab reports are slow in getting to patient charts—which can lengthen days of stay for inpatients. Autopsy reports are inordinately slow in completion.

There is a badly needed reorganization of facilities at the VAMC, which may have to wait on completion of the new wing—which increases urgency of this need. For example, all Operating Rooms are on Floor 1—the Surgical Intensive Care Unit is on Floor 8. This means surgery patients are taken from surgery to the 8th Floor, using hallways and overcrowded elevators. Even as a layman I know this is extremely inadvisable—but it is being done daily. Dietetics needs more space. Pharmacy needs more space. Warehouse space is woefully short.

Pharmacy Service is understaffed with one of the heaviest pharmacy work loads in the system. A minimum of 24 FTEs would be needed to proceed to the unit dose system.

Surgical Service reports a need for at least 4 more FTE's.

Medical Service reports itself short 2 physicians and in need of at least 7 FTE support staff.

Prosthetics, which is very busy reports a need for 5 FTE's to provide proper service.

Rehabilitation Medicine Service is 5457 square feet short of needed space, using DM&S standards. With a present staff of 30 therapists, 18 more are needed.

Dental Clinic, though properly equipped, needs better organization of functional space—which perhaps is not possible until completion of the projected new wing. Dentistry also complains it is shorted seriously in provision of continuing education funds.

Staff complains about continuing education funds. VAMC San Juan is provided such funds on same basis as VAMC's stateside—which does not recognize excessive distances that must be travelled by San Juan personnel to attend seminars, workshops, special courses, etc. DM&S should certainly take note of this, which seems to be an obvious fact.

Security Service, with a present ceiling of 31, needs 3 or 4 more positions assigned, to compensate for excessive absenteeism, which apparently cannot be contained.

An effort is made to control contraband, with mediocre results.

Most violations are disorderly conduct and assaults on both patients and staff.

Security Chief and top management agree that all security personnel are graded too low by one or two grades. It is my realization this is a system-wide problem.

There is some patient and government property thievery. Efforts are made to control this. It is perhaps inevitable in such a large and busy institution.

Drug Dependence Clinic treats both substance and alcohol abusers with a multiple faceted mix of treatment modalities. NP Chief believes it is effective. Efforts are made to provide intervention through the NP ICU—which may be the only such unit in the system. I believe an inpatient unit providing a structured rehabilitation program is needed, rather than the present reliance only on the outpatient clinic. Alcohol and substance abuse are a measurable problem among Puerto Rico veterans—a condition shared by the veteran population generally.

Research Program has problems, mainly revolving around funding shortages. I did not have opportunity for thorough discussion of the research program, which has to be important in a hospital as sophisticated as this one. I was informed the viability of the research program is in question. I urge DM&S to investigate this situation and undertake remedial action before the program becomes moribund.

Mayaguez and all contract facilities on the island were included in this visit. The Mayaguez Clinic was the one unrelieved element of VA functioning at its best. The clinic is well situated, properly equipped and staffed and doing its job on a daily, productive basis. The Mayaguez Clinic could be used as a model by any satellite clinic in the system.

Contract facilities in Ponce, Damas and St. Luke's Hospitals, are satisfying the need for service in that area. The American Legion will support establishment of a

clinic operation similar to that of Mayaguez in lieu of the contract arrangements now in place.

In San Juan the contract facilities, Hato Rey Hospital and Fernandez Garcia Clinic, I was told, meet JCAH standards. They are staffed with professional medical personnel and are caring for a large number of veterans who otherwise would receive no VA care. For that reason they must be supported. The ambience prevailing in these institutions is—grim.

To whatever extent the projected new wing at VAMC will reduce need for contract facilities, this should be accomplished.

In defense of Hato Rey, it should be reported that institution has commenced construction of a new facility that, I was informed, will incorporate the latest physical and professional psychiatric treatment modalities.

The American Legion naturally believes it can provide more meaningful oversight in a VA operated institution.

Other observations in passing: VAMC San Juan is the most sophisticated practicing and teaching institution, not only in Puerto Rico, but in the entire Caribbean Basin. Other Caribbean countries send delegations to VAMC to learn about the practice of modern medicine.

VAMC San Juan has one of the highest levels of professional staff to be found in the system. At all levels staff turnover ratio is one of the lowest in the system. This is no doubt partly due to the fact that VA salary scales for all levels of positions are attractive in the Puerto Rican economy. But my personal observations and contacts with all levels of staff lead me to believe low turnover is also due to dedication to the VA mission. If it were not for this fact, VA in Puerto Rico would not be providing the quality and quantity of care that is indeed being provided.

Having said these things, and acknowledging that the Federal Government has provided special conditions to assure care for a large number of Puerto Rico veterans, nevertheless these facts are balanced by certain countervailing factors.

First is the condition of the Puerto Rican population. Half the population subsists at the Federally designated poverty level.

Second, the population experiences mental health problems at twice the level of the American population.

Third, community resources are, for most purposes scarce or nonexistent—especially in the mental health field.

All of the above are inevitably reflected in the veteran population, and impact on VA's efforts to meet Federal responsibilities on the island.

Finally, the point must be made that while the Federal Government has a direct and immediate obligation to the veteran population of the nation—a fact that is generally acknowledged—that Government has a special obligation to the veterans of Puerto Rico. The Puerto Rican people, while they are American citizens, and share in all the responsibilities attaching to citizenship, including that of military service, do not share fully in the blessings and benefits of being Americans. They are an island people. They are not a state. They subsist in a limited economy that, if the nation is in a recession, is in a depression. The unemployment rate in Puerto Rico is conservatively estimated at 24 percent—double that in the United States.

On the basis of all of these factors, The American Legion which has a large organization in Puerto Rico, must stand by the veterans of the island and ask VA, and the Congress to address, on an immediate basis, the most acute of the problems being confronted by the agency on the island of Puerto Rico. The United States—noted for its generosity to other peoples—including former enemies—certainly cannot afford to be niggardly in dealing with a people on whom it has conferred citizenship, and from whom it requires military service in all of its wars.

The American Legion requests VA to estimate what is needed to promptly address the most acute needs in Puerto Rico and to seek funds from Congress to meet these needs, and the Legion petitions Congress to provide necessary funds to take care of the veterans of Puerto Rico.

The American Legion will appreciate a response to this communication. It realizes it will receive an answer that will devolve from reference to "system-wide priorities," but we believe Puerto Rico is in need of and deserving of consideration at this time, outside system-wide priorities.

The observations and recommendations included in this communication will be shared with the appropriate Congressional Committees, and with the Administrator.

Sincerely,

R. E. LYNGH,

Director, National Veterans Affairs and Rehabilitation Commission.

PREPARED STATEMENT OF BOB MORAN, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. Chairman and Members of the Subcommittee, Paralyzed Veterans of America is grateful for this hearing, which demonstrates the Subcommittee's continuing concern for the current and future health care needs of our nation's veterans.

PVA appreciates this opportunity to submit its views and concerns on the Veterans Administration's hospital construction program and plans. As you know, PVA's members all are veterans who have experienced spinal cord injury or disfunction, and these veterans have considerable contact with the VA health-care system and the facilities in which the VA extends medical and health-care services.

PVA's statement will concentrate basically on three areas: first, it will examine the VA's fiscal year 1985 construction plans, including MEDIPP. Second, it will look into the needs of spinal cord injured veterans and examine some possible VA construction projects which would help ensure more adequate care for spinal cord injured veterans. And, finally, we will be commenting on the provision of health care services to the veterans of Puerto Rico.

FISCAL YEAR 1985 CONSTRUCTION PLANS

Mr. Chairman, PVA welcomes the President's proposal to continue to provide significant funding for the Veterans Adminstration's construction of health-care facilities. The construction budget request of $822 million in new budget authority indicates that this Administration recognizes the importance of adequate facilities, if the VA is to perform its assigned functions. This is particularly true regarding the emphasis on the construction of new nursing home facilities. The needs of the aging veteran population will continue to place ever-growing demands on the VA's helath-care delivery system, and it is extremely important that adequate physical facilities be developed and maintained to meet this demand.

Mr. Chairman, the construction proposal is a postitive sign; however, it raises several questions. Over the past several years we have seen construction proposed (and even initiated) at sites during one fiscal year, only to be eliminated or postponed the following year. We must question the viability of long-range planning for VA construction. The replacement hospital in Baltimore, Maryland, is an example of a clearly stated need, but the start of the construction process has disappeared from the VA's construction plans. Again, this year, the budget contains no funds for this project.

The current Five-Year Medical Facility Construction Plan lists the Balitmore project as one of the medical centers most in need of construction, replacement of major modernization. In 1976, President Ford announced that a 400-bed hospital would be constructed in Baltimore. Funds were appropriated in fiscal year 1977 and to date the VA has spent approximately $8 million on this particular project. Now, according to the VA, the project has been cancelled due to budgetary constraints. Undoubtedly, because of the undeniable need in this area, some form of replacement/modernization will have to be undertaken in the futrue. To modernize an existing facility after spending $8 million on design and the purchase of a construction site, would seem to be an unjustified waste of money.

Likewise, funding for the Philadelphia, Pennsylvania VA medical center has not been included in the fiscal year 1985 budget. Again, the project has continually been put on the "back burner" with the total estimated cost increasing with each delay. As with Baltimore, the Philadelphia project is totally justified and needed. The conditions under which the Philadelphia VAMC staff and patients provide and receive treatment are distressing. The recognized need for improvement and expansion of the medical center is such that the city of Philadelphia has recently offered to donate land for the projects; provided funding and construction are "begun" by December 31, 1986. It is our understanding that some confusion exists as to whether the total construction project must be started or whether a part of it could now be undertaken to safeguard the availability of the donated land. It would certainly be tragic to lose the land in question because of misunderstanding.

The failure to construct needed VA medical and health-care facilities has been one of the most troublesome veterans issues for quite some time: by "contruction"; PVA means both the building of needed new facilities and the maintaining of existing ones. It is a very serious matter that so many VA facilities are now in a state of decay, after a grateful nation has provided them, some are only marginally meeting the needs of the veterans who use them. Decaying facilities not only hamper patient usage of some VA medical facilities, but their poor conditions makes it doubly difficult to recruit and retain highly capable health-care professionals. Thus begins a vicious circle of waste in which ailing veterans are too often caught.

Mr. Chairman, we just also point out what we view as an impediment to efficient management of the VA's contruction programs.

Maintaining a separate Office of Construction within the VA seems like a needless duplication, especially since approximately 90 percent of the work done by the Office of Construction is for the Department of Medicine and Surgery. Furthermore, these two departments within the VA often have differing or conflicting goals and views complications which make construction more costly than it need be. A dichotomy exists within the structure of the VA, where the Chief Medical Director bases construction needs, criteria, and timetables on the assessment of existing and future patient requirements, but the Office of Construction only bases construction needs and timetables predicated on existing and projected budget considerations.

The Chief Medical Director is more capable of judging patients' needs, as he is more capable of determining what facilities should be designed in a particular manner so that they will be optimally functional for VA health-care professionals who must work in these facilities caring for patients.

Furthermore, the Chief Medical Director already must consider budget matters as he looks toward accomplishing his mission; therefore, it is not as if he would act irresponsible should construction be placed under his control. It would simply mean that the same individual could evaluate a number of considerations and implement medical care and construction planning with less conflict and fewer delays, and an often incongruous coordination step could be eliminated.

VA feels that the Office of Construction should be placed within the Department of Medicine and Surgery, under the supervision of the Chief Medical Director. Then, construction would be an integrated part of the VA medical system and there would be fewer disruptions and less opportunity for veterans to be caught in conflicts which now arise as separate branches of the Veterans Administration disagree over ways to care for their needs. Less duplication of effort within the VA as it approaches construction projects would produce facilities more quickly and at less cost to the government.

In addition, Mr. Chairman, we must address the VA's plans for expanding and improving facilities for aging veterans.

PVA is pleased to see, because of the increasing average age of veterans, that $50.8 million is included for the design and construction of seven nursing home care units located in Alexandria, Louisiana; Durham, North Carolina; Mufreesboro, Tennessee; Prescott, Arizona; Providence, Rhode Island; San Juan, Puerto Rico; and West Los Angeles, California. The Durham, North Carolina nursing home is scheduled to include a Geriatric Research and Clinical Center (GRECC). PVA applauds this action but wishes to note that the current number of GRECC's still falls short of the 15 authorized by P.L 96-330. We believe the GRECC program gives much needed viability and respectability to geriatrics and will serve to encourage medical practioners to advance this emerging medical specialty. Further evidence of the growing concern for our elderly veterans is demonstrated in the increase from $18 million to $35 million in the grant program for the construction of state extended care facilities. These facilities play a vital role in the care of the aging veteran, and this increase will certainly help reduce the backlog of requests for such grants, reducing the demands on similar facilities within the VA.

In regard to the topic of long-term care and the aging SCI veteran, PVA would remind the VA that its long awaited "Prototype Nursing Home" plans fail to contain provisions for patient use by some of the VA's most catastrophically disabled veterans. Specifically, none of the proposed patient units meets the VA's own SCI space criteria, although general wheelchair accessibility as defined by VA regulation CD 28 does exist. We trust corrective accommodation in "Prototype Nursing Home" standards can be made administratively, and we would encourage the VA to consider, at a minimum, that at least one four-patient unit be included in each facility to meet the VA's SCI space criteria.

Finally, Mr. Chairman, to this general failure by the VA to adequately address the needs of aging spinal cord injured veterans is the specific problem of modernization at VAMC, Brockton, Massachusetts. PVA has reviewed the VA's proposal for Brockton and finds it unacceptable. Rather than detailing the many problems in the plan, I am attaching, as an addendum to this statement, a review of the design conducted by Mr. Thomas T. Hodne, an architect employed by Eastern PVA.

MEDIPP—MEDICAL DISTRICT INITIATED PLANNING PROCESS

Today, the VA is showing an unprecedented interest in the accurate placement of health-care facilities. Medical District Initiated Planning Process (MEDIPP) is the VA's latest management practice being utilized to begin the identification and de-

velopment of medical facilities needed at the medical district level, and to formulate construction plans to meet these needs on a district-wide basis rather than the older policy of a station-by-station assessment. We applaud the MEDIPP concept, we think this approach to VA medical facility planning will not only better address the long-term needs of the VA, but, more importantly this approach will allow for more unified construction plans while at the same time permitting regional differences to be realized.

Of significant concern and importance to PVA is the provision of SCI services within the VA health-care delivery system. The SCI service is a unique program within the VA and does not fit neatly into the MEDIPP process. PVA is pleased to be working with the VA Central Office in providing data on potential sites for new SCI Centers. And, hopefully this information is proving useful to the more localized efforts to MEDIPP. In addition, we are finding that some medical districts are making plans to include SCI Centers, but there appears to be poor coordination between districts as to SCI veterans needs. The question then becomes who speaks for the needs of the VA spinal cord injured veteran.

Special consideration must be given to this particular subset of all veterans, and the VA should not rely upon general statistics from the general veteran population in making these decisions. PVA will continue to monitor the needs of SCI veterans and we will continue to investigate potential new sites for SCI centers. In this regard we request the VA to continue to take the following factors into consideration when selecting the site for an SCI Center: availability of a suitable existing structure readily accessible in terms of geography and transportation facilities; strong affiliation with a medical school; and proficiency of medical staff in the disciplines critical to spinal cord injury care and research.

SCI CARE

Mr. Chairman, PVA is pleased with the VA's continued recognition of the changing needs of spinal cord injured veterans. The latest five-year plan for SCI services includes provision for the creation of seven additional SCI Centers which will add 180 beds to the Service. The anticipated growth in the SCI Service is a clear reflection of the on-going needs of SCI veterans and is in keeping with the VA's own projections for necessary facilities. We applaud the VA's efforts and encourage this Subcommittee to continue to monitor the SCI Service.

The VA has prepared two comprehensive studies of SCI veterans and an analysis of the demands they will make on the VA health-care system. These studies are entitled "The Spinal Cord Injury Program Plan: Fiscal year 1980–1987" and "Estimated Bed Requirements of the Spinal Cord Injured Veteran, 1984–1990." The first noted study is a broad analysis of the VA's SCI program (to include staffing needs, medical specialties required, and other appropriate health-care matters), and at the very core of the study is the assumption that VA SCI Centers will be placed where needed in order to better service veterans who experience spinal cord injuries.

The essential point is that at the time of publication, the VA had five fewer SCI Centers than it does today, and was able to extend care to nonveterans on a space-available basis: today, there are few if any SCI beds available for nonveterans.

In early 1980 the Veterans Administration had 1,365 SCI beds, which is about the same number as exists today, four years later. Even though Centers have been added to the SCI Service, the size of existing facilities has been reduced, and entire SCI wards have been closed. At the time of its study, however, the VA estimated that by Fiscal Year 1985, 1,845 beds as a minimum would be needed in the SCI Program.

The VA admitted that this figure was low and that it was based on an assumption that only 25 percent of all SCI veterans would require hospital services in any given year. It was based, also, upon the stated assumption that there would be nor more wars.

Given a situation whereby all existing SCI veterans would require routine hospital services in a given year, the VA estimated that 6,439 SCI beds would be needed. PVA maintains that an accurate figure of SCI beds needed is somewhere between these two estimates (1,845 to 6,439). Either way, though, it is clear that increased SCI services and beds are needed. (Source, VA's Estimated Bed Requirements of the Spinal Cord Injured Veteran, 1984–1990.)

There are a number of significant findings revealed in a recent demographic study of SCI veterans which should be highlighted in any discussion of the needs of SCI veterans. (This study was conducted jointly by the VA and PVA). Most SCI veterans respondents to questionnaires (which PVA mailed to 97,889 veterans whose disabilities indicated that they are potentially spinal cord injured) served in World

War II (51 percent) and are over 50 years of age (64 percent). Sixty-four percent (64 percent) of all the SCI respondents are service-connected disabled veterans, while thirty-five percent (35 percent) are nonservice-connected. Sixty-seven percent (67 percent) of those surveyed responded that they use VA facilities.

It is difficult to ascertain from the data available on SCI veterans demographics and their usage of the VA system what exactly is the frequency of use; however, it is helpful in understanding the intense usage of the VA SCI system. When the data was gathered, there existed only 1,365 VA SCI beds in the system, yet 16,279 individual SCI veterans were treated between fiscal year 1976 and fiscal year 1981.

Whenever SCI veterans who require long-term care are forced by bed shortages to occupy acute-care beds, a number of undesirable results occur. First, this is a waste of money, to keep persons in the most expensive beds continuously, when what they actually need is daily personal assistance and access to acute-care facilities only when medical emergencies arise. This is the reason that PVA supports placing SCI Centers on the campuses of general VA Medical Centers. Long-term care SCI facilities should then be attached to the SCI Centers, and those SCI veterans in need of acute care can then be transferred quickly to appropriate facilities.

Second, SCI veterans who do not require long-term care, and who do not require hospitalization, still require regularly scheduled medical checkups, to ensure that problems are diagnosed before they become critical and possibly life-threatening. When emergency situations develop, or when routine checkups are needed, beds are too often already filled with less-seriously ill SCI patients (who would find long-term care actually to be more appropriate). The result is that these long-term care SCI patients must be moved out of the SCI unit to wards where the personnel are not experienced in dealing with their medical needs.

Because of the bed shortage, emergency admissions mean, first, that long-term care patients must be moved about, and second, that SCI veterans who have examinations scheduled must be abruptly notified of cancellation and rescheduling. This can be especially frustrating for catastrophically disabled veterans who have special travel problems which must be arranged in advance. Also, the problem is further aggravated when SCI veterans must plan to travel long distances, as is often the case in states where populations are dispersed over great geographical distances.

PUERTO RICO AND THE VIRGIN ISLANDS—HEALTH CARE FACILITIES

PVA will reserve comments on health care of veterans on the Virgin Islands, because we understand the contracting authority by the Veterans Administration is working satisfactorily.

Presently, there are no VA nursing homes in Puerto Rico, so we were certainly pleased to see the $9 million in the VA's fiscal year 1985 budget for the construction of a 120 bed nursing home and a 10 bed blind rehabilitation center. We are confident Congress will aprove both of these much needed facilities.

Our concern is to secure, for veterans living in Puerto Rico, the same quality of health care that those veterans living on the Mainland receive. PVA has an active Chapter of over 100 members who all have spinal cord injury or dysfunction. We believe we can appropriately address the issue of care for those veterans living on the Island, who require and have considerable contact with the VA health care facility.

The GAO report in 1978 portrayed a VA health care system in urgent need; this picture was reinforced by the VA in reports to you in 1981, and again in January 1983, which currently remain.

The VAMC, and its clinics are crowded all of the time, the hospital maintains a daily average of 90 percent saturation. The hospital has one of the lowest staff to patient ratio in the VA system. The problems, as we were made aware of, are more with personnel than with equipment. The shortage of registered nurses, with the overcrowding of seriously ill patients increases the chances of employee problems and turnovers; it is only through dedicated health care professionals and the economic climate that favors VA employment.

We are aware of the VAMC in San Juan having to compete with other facilities in medical District #3 for funds to implement improvements; however, we believe that special consideration should be given to Puerto Rico. Puerto Rico's size and distance from the mainland, the ecomomic situation, unavailable community facilities, the magnitude of psychiatric problems, and an ever aging veteran population provide greater health problems and increase health needs.

The point must be made that while the federal government has an obligation to the veteran population of this nation, the government has a special obligation to the veterans of Puerto Rico. They are an Island of Americans, who share in the respon-

sibility of insuring a free society, and they do not fully share the blessings and benefits of being Americans.

When all of the factors mentioned are carefully examined, PVA and the veterans of the Island must ask the VA and Congress to assess the most acute needs in Puerto Rico and to seek funds to meet these needs.

EASTERN PARALYZED VETERANS ASSOCIATION,
New York, N.Y., February 22, 1984.

Mr. VICTOR S. MCCOY, Sr.,
National Service Director, Paralyzed Veterans of America, Washington, DC.

DEAR VIC: Enclosed is a brief report on the Brockton SCI proposal.

As I mentioned yesterday, everything about it is a compromise and most of the patient bedrooms are too small, which results in a situation when none of the critical dimensions can be adhered to, especially if the new larger beds are going to be used.

The Hopper/Shower/W.C./Tub area, or whatever it is called on these drawings, is a strange layout; I really can't make too much sense out the whole arrangement.

Overall, I would say that this project represents a giant step backwards in Spinal Cord Injury care and, as such, should be scrapped.

Sincerely yours,

THOMAS T. HODNE,
Planning & Design Director.

Enclosure.

VA-SCI CRITERIA COMPLIANCE REPORT

BY: Thomas T. Hodne, Planning and Design Director, Eastern Paralyzed Veterans Association.

TO: Victor S. McCoy, Sr., National Service Director, Paralyzed Veterans of America.

DATE: Febuary 21, 1984.

PROJECT: Renovate Building #8—Patient Privacy, Fire & Safety Seismic.

LOCATION: VAMC, Brockton, Mass.

PROJECT NUMBER: 525-021.

GENERAL INFORMATION

As with all previous review of proposed SCI construction, this report is a simple comparison of information shown on actual plans with regard to compliance and adherence to existing VA Space Planning Criteria.

The VA documents used for compliance review comments that follow are:

(1) (H-08-9) Chapter 104—Spinal Cord Injury Units—Draft No. 14, February 28, 1983.

The 13 drawings submitted for review are dated November 1, 1983 and titled "Second Post Final Preliminary Submission."

REVIEW COMMENTS

The following comments are based on VA-SCI requirements for 56 Long Term Care beds in the configuration of 2 contiguous 28 Bed Nursing Units.

Drawing No. 1

1. Title Page—No comments.

Drawing No. 2

2. The parking layout is not delineated or dimensioned so the number and sizing of reserved parking spaces for SCI patients can not be determined. Refer to 104.06-f.

3. There are four new concrete pads connecting with new bituminous walkways; the northernmost walkway leading to the parking spaces on Plymouth Drive exceeds the maximum allowable slope for a walkway or ramp. Refer to (H-08-3)4.a.

Drawing No. 3

4. No comments.

Drawing No. 4

5. No comments.

Drawing No. 5

6. Wheelchair Storage (Room BC-14 @ 140 NSF) is too small, it should be at least (56 × 3.5) 196 NSF. Refer to 104.05-g.2.

7. Building Management Storage (Room BC-16 @ 81 NSF) is too small, it should be 100 NSF. Refer to 104.05-b, (6).

8. Should a Trash Collection room, at 60 NSF, be provided? Refer to 104.05 b. (8).

9. The Game (BC-2 @ 225 NSF) is too small, it should be 300 NSF. Refer to 104.05 a (17).

10. PVA Office (Room BC-1 @ 100 NSF) is too small, it should be 120 NSF. Refer to 104.5-c. (13).

Drawing No. 6

11. Although the 2 Bedrooms (1A-141, 1A-142, 1A-179) exceed the 320 NSF space criteria they are configured in such a way that the 5 foot side clearances and 7 foot aisle widths are not provided. Refer to 104.06-k. (1)(c).

12. The 1 Bedroom (1A-178 @ 175 NSF) is too small and does not provide 5 foot side clearances. Refer to 104.05 a. (2) and 104.06-k. (1) (b).

13. The 3 Bedroom (1A-146 @ 455 NSF) is too small and does not provide the minimum 5 foot side clearances, 7 foot aisle width, and 10 feet bed spacing. Refer to 104.05, 104.06-k (1) (2).

14. The Dining Room (1A-143 @ 1200 NSF) is undersized, it should be (56 × 23) 1288 NSF. Refer to 104.05-b. (3)(a).

15. Administrative Office space has been provided for the Chief of Service, Administrative Assistant or Dietitian. Refer to 104.05-c. (1)(5)(11).

Drawing No. 7

16. The 2 Bedrooms (1B-124, 1B-123, 1B-118, 1B-117, 1B-114) are too small and do not provide the 5 foot side clearances. Refer to 104.05 a. (2) and 104.06-k. (1)(b).

17. The Bedrooms (1B-127 and 1B-129) are too small and do not provide the 5 foot side clearances.

18. The number of bathrooms provided for the 2 and 5 Bedrooms is inadequate; only 2 bathrooms are shown while at least 4 are required. Refer to 104.05 a. (4) (b) 3.

19. The Nursing Station does not provide adequate space for the Ward Clerk function. Refer to 104.05 a. (8)(c).

20. The Conference Room (1B-135 @ 225 NSF) is too small.

21. The entire area designated as Hopper/Shower (1B-132) Tub & Shower (1B-132A) and W.C. Toilets (1B-132B) is difficult to assess with regard to the SCI Space Criteria. Refer to 104.05 a.(6)(7) and 104.05 a. (5)(a) 1., 2.

Drawing No. 8

22. The comments for this drawing are basically the same as for Drawing No. 7, only the room numbers are different.

Drawing Nos. 9 through 11

23. No. comments.

Drawing No. 12

24. See comments for drawing No. 7.

Drawing No. 13

25. No comments.

GENERAL COMMENTS

The SCI Program Plan fiscal year 1980-1987 states that Brockton will be an 80 Bed Long Term Care SCI facility; This proposal is for 56 beds and everthing about it seems to be a compromise or non compliance with existing criteria.

PVA is concerned with patient care and compliance with VA-SCI criteria. Since the SCI Criteria is an evolving set of standards based on many years cumulative knowledge of what is best for SCI patients I don't see how this project can go ahead with any sort of PVA endorsement.